Supreme Court, U.S.
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No. 00-

IN THE

Supreme Court of the United States

AMERICAN MEDICAL SECURITY, INC.,

Petitioner,

v.

AAA MICHIGAN,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The lower court held that a state priority of coverage rule which addresses conflicting coordination of benefits provisions, though not directed specifically at the insurance industry nor applicable only to insurance contracts, was nonetheless saved from ERISA preemption because it was principally directed to various types of coverage.

The question presented is whether a state law directed at regulation of broadly defined health benefit plans and entities, only some of which fall within the insurance industry, is a law which regulates insurance within the meaning of ERISA's savings clause and thus, survives ERISA preemption.

STATEMENT PURSUANT TO RULE 29.6

Petitioner, American Medical Security, Inc., states that it is a wholly owned subsidiary of American Medical Security Group, Inc.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The district court's opinions granting respondent's motions for summary judgment (Appendix B - Memorandum and Order and Judgment of the United States District Court for the Eastern District of Michigan, Southern Division Dated and Filed September 9, 1999, pg. 28a-37a and Appendix C - Memorandum and Order and Judgment of the United States District Court for the Eastern District of Michigan, Southern Division Dated and Filed August 4, 1998, pg. 38a-46a) are not published. The court of appeals' opinion affirming will be published. (Appendix A - Opinion and Judgment of the United States Court of Appeals for the Sixth Circuit Dated, Decided and Filed January 4, 2001, pg. 1a-27a).

JURISDICTIONAL STATEMENT

Petitioner filed two separate actions under § 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 891, as amended, 29 U.S.C. § 1132(a)(1)(B). Both cases were heard before the same district judge, who granted summary judgment in favor of Respondent and against Petitioner on separate grounds. Petitioner appealed the two separate judgments to the United States Court of Appeals for the Sixth Circuit, wherein the two cases were consolidated.

The court of appeals invoked its jurisdiction pursuant to 28 U.S.C. § 1331, as Petitioner's claims arose under 29 U.S.C. § 1132(a)(1)(B) of ERISA, and entered its opinion and order on January 4, 2001. Petitioner invokes this Court's jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

A. ERISA Preemption Provisions

ERISA's preemption clause § 514(a), 29 U.S.C. § 1144(a), states:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to an employee benefit plan.

The saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), states:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

B. The State Law

The state law involved is Michigan's "Federal Kemper rule." In *Federal Kemper Insurance Co., Inc. v. Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W.2d 590, 596 (1986), *overruled in part by Auto Club Ins. Ass'n v. Frederick & Herrud, Inc.*, 443 Mich. 358, 505 N.W.2d 820 (1993), the Michigan Supreme Court developed a priority of coverage rule where a conflict exists between a Michigan no-fault automobile insurer which has issued a coordinated policy under Section 3109a of Michigan's No-Fault Automobile Act and an accident victim's other health coverage provider which also coordinates coverage, such that the other health coverage provider will be deemed primary. Section 3109a provides in relevant part as follows:

> An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions

> reasonably related to other health and accident coverage on the insured . . .

Mich. Comp. Laws Ann. § 500.3109a (West 1993).

STATEMENT OF THE CASE

Petitioner, American Medical Security, Inc. ("AMS"), is a third-party administrator of insured employee welfare benefit plans governed by ERISA. AMS filed this suit for reimbursement of benefits which AMS had paid on behalf of three separate individuals who were participants or beneficiaries under separate ERISA plans. The individuals: Peter C. Coan ("Coan"), Jerry Williamson ("Williamson") and Andrea Teagan ("Teagan") were each injured in separate automobile accidents.

The subject ERISA plans administered by AMS do not provide benefits for injuries for which there is other medical expense coverage. It is undisputed at the time of each automobile accident, the insured had other medical expense coverage provided by Respondent, Auto Club Ins. Ass'n of Michigan ("AAA Michigan"). However, the automobile insurance policies also include coordinated coverage provisions and likewise, do not provide benefits where the insured has other medical expense coverage.

AMS paid the insured's medical expenses and requested reimbursement from AAA Michigan. AAA Michigan refused to reimburse AMS. With respect to Coan and Williamson, AAA Michigan asserted the request was untimely. With respect to Teagan, AAA Michigan asserted the ERISA plan was "not self-funded." The two lawsuits resulted.

Since the appeal involved two lawsuits which were consolidated, it appears most helpful to address the facts as the Sixth Circuit did, in a section for "Coan and Williamson - Docket No. 98-1973" and "Teagan - Docket No. 99-2110."

A. Coan and Williamson- Sixth Circuit Case No. 98-1973.

On April 26, 1992, Peter C. Coan ("Coan") was injured in an automobile accident. At the time of the accident, Coan was employed by Daniels Glass Co., Inc., and was a participant in its employee benefit plan. AMS, the third-party administrator of the plan, paid $197,857.85 for medical expenses Coan incurred as a result of the automobile accident.

On April 13, 1993, Jerry Williamson ("Williamson") was injured in an automobile accident. At the time of the accident, Williamson worked for C & M Masonry and was a participant in its employee benefit plan. AMS paid $8,239.38 for medical expenses Williamson incurred as a result of the automobile accident.

On January 23, 1996, AAA Michigan denied AMS' request for reimbursement on behalf of Williamson stating that AMS' request was not made within one (1) year from the date of the accident or the date of the last medical service and was thus barred under the one-year statutory limitation period set forth in M.C.L. § 500.3145(1); M.S.A. § 24.13145(1). On February 26, 1997, AAA Michigan denied AMS' request for reimbursement on behalf of Coan on the same ground. AAA Michigan agreed the claim would be timely if the applicable limitation period was the six-year "contract" or "general" limitation period pursuant to M.C.L. § 600.5807(8); M.S.A. § 27A.5807(8), however, there was no authority in federal or state court addressing which limitation period was applicable in the instant dispute.

On August 28, 1996, a State trial court held the applicable statute of limitations for AMS' reimbursement action under 29 U.S.C. § 1132(a)(1)(B), to be six years. The State trial court ruled in favor of AMS and held the reimbursement action was governed by the six-year "contract" or "general" statute of limitations pursuant to M.C.L. § 600.5807(8); M.S.A. § 27A.5807(8). *American Medical Security, Inc. v. Auto-Owners Ins. Co.*, State of Michigan 15th District Court, Case

No. CIV 96-1182-GC, August 28, 1996. The court also held that the no-fault carrier was primarily liable for the medical expenses resulting from an automobile accident and ordered the no-fault automobile insurer to reimburse AMS for the medical expenses.

AMS forwarded a copy of the opinion to AAA Michigan. The State trial court opinion was not binding precedent, it was simply the first ruling on the relevant statutory limitation period in reimbursement cases between insured ERISA plans and Michigan no-fault automobile insurers. AAA Michigan disregarded the opinion and denied AMS' request for reimbursement asserting it was untimely under M.C.L. § 500.3145(1); M.S.A. § 24.13145(1).

On November 12, 1997, AMS instituted its action against AAA Michigan in the United States District Court for the Eastern District of Michigan seeking reimbursement of the medical expenses AMS had paid for Coan and Williamson's injuries resulting from the automobile accidents. AAA Michigan argued the action was time-barred. The parties also addressed the substantive issue as to which party was primarily liable for the medical expenses where an insured ERISA plan and a no-fault automobile insurance policy each contained conflicting excess coverage provisions.

The district court never reached the substantive issue as it held AMS' action was time-barred. (Apx. C, pg. 40a n.2). On August 4, 1998 the district court entered is Opinion and Order which held AMS' claims were untimely pursuant to the "one-year back" rule of the Michigan No-Fault Automobile Insurance Act. (Apx C, pgs. 39a-46a). AMS timely filed an appeal in the Sixth Circuit where the case was assigned Docket No. 98-1973. The case was held in abeyance pending resolution of the second lawsuit involving another common insured, Andrea Teagan.

B. Teagan - Sixth Circuit Case No. 99-2110

On July 8, 1994, Andrea Teagan ("Teagan") was injured in an automobile accident. At the time of the accident, Teagan was covered under her mother's employee benefit plan sponsored by Tempo West, Inc. AMS paid $205,317.89 for Teagan's medical expenses resulting from the automobile accident and then requested reimbursement from AAA Michigan.

AAA Michigan initially denied AMS' request for reimbursement with respect to Teagan on May 20, 1997. Unlike the requests for Coan and Williamson, AAA Michigan did not deny the request based on the "one-year back" rule of the Michigan No-Fault Act. Instead, AAA Michigan denied the reimbursement request with respect to Teagan because the subject ERISA plan "was not self-funded."

AMS responded to AAA Michigan and provided copies of the numerous judgments issued by State of Michigan trial courts which had ruled in favor of AMS on the primacy of coverage issue. The State trial courts had at this point in time, consistently held in favor of the insured ERISA plans in: *American Medical Security, Inc. v. Auto-Owners Ins. Co.*, State of Michigan District Court for the County of Washtenaw Case No. CIV-96-1182-GC (August 28, 1996); *American Medical Security, Inc. v. Allstate Insurance Company*, State of Michigan Oakland County Circuit Court Case No. 95-506446-CZ (September 5, 1996); *American Medical Security, Inc. v. Nationwide Mutual Fire Ins. Co.*, State of Michigan 46th District Court No. GC 96-0907 (November 22, 1996); aff'd in the State of Michigan Oakland County Circuit Court Case No. 96-DA6736-AV (May 14, 1997); *American Medical Security, Inc. v. Allstate Insurance Company*, State of Michigan Wayne County Circuit Case No. 96-624567-NF (July 3, 1997); *American Medical Security, Inc. v. Farmers Insurance Exchange*, State of Michigan 47th District Court Case No. 95H605567 GC (October 2, 1996); *American Medical Security, Inc. v. State Farm Mutual Automobile Insurance Company*, State of Michigan Wayne County Circuit

Court Case No. 96-634535-NF (June 20, 1997); *American Medical Security, Inc. v. Farm Bureau Insurance Company*, State of Michigan 41B District Court Case No. MC97-1350NF (December 19, 1997); *American Medical Security, Inc. v. Titan Insurance Company*, State of Michigan 43rd District Court Case No. GC 980043 (June 4, 1998); Also see *Allstate Insurance Company v. American Medical Security, Inc.*, 975 F. Supp. 1005 (E.D. Mich. 1997).

The State trial court opinions were, of course, not binding and AAA Michigan disregarded them. AAA Michigan advised AMS that its position remained the same and denied AMS' request for reimbursement stating the insured ERISA plans "were not self-funded." AMS filed the second lawsuit against AAA Michigan on April 27, 1998.

Once again, AMS and AAA Michigan filed cross-motions for summary judgment. Several days before the hearing, the Michigan Court of Appeals issued two opinions: *American Medical Security, Inc. v. Allstate*, 235 Mich. App. 301, 597 N.W.2d 244 (1999), *cert. denied*, 461 Mich. 1003 (2000). (sometimes referred to as "*Perri*", the name of the common insured) and *American Medical Security, Inc. v. Allstate*, No. 206300 (Mich. App.) (rel'd 4/23/99) (unpublished) (sometimes referred to as "*Guiles*", the name of the common insured). In *Perri*, the Michigan Court of Appeals held ERISA preempts the subject state law (the "Federal Kemper rule") only with respect to self-funded employee welfare benefit plans and not "insured" employee benefit plans. In *Guiles*, the Michigan Court of Appeals held the dispute was governed by the "one-year back rule" of the Michigan No-Fault Act.

On September 9, 1999, the federal district court granted AAA Michigan's motion for summary judgment and denied AMS' motion for summary judgment. (Apx. B, pgs. 28a-37a). AMS filed a Claim of Appeal of the September 9, 1999 Judgment and it was assigned Docket No. 99-2110. The Sixth Circuit consolidated Docket Nos. 98-1973 and 99-2110.

On January 4, 2001, the Sixth Circuit issued its Opinion and affirmed the district court's grant of summary judgment in favor of AAA Michigan. (Apx. A, pgs. 1a-27a). AMS petitions this Court for writ of certiorari as the Sixth Circuit has decided an important federal question in a way that conflicts with relevant decisions of this Court.

REASONS FOR GRANTING THE WRIT

The Sixth Circuit's decision conflicts with holdings of this Court and of other circuits. The lower court has broadened the savings clause to include state laws which are not specifically directed toward insurers and insurance contracts, but rather, state laws which are "principally directed" at various types of coverage providers including insurers. Although state laws which regulate insurance within the meaning of the savings clause are not limited to "traditional" insurance, this state law is directed to all "coverage" providers including not only insurers, HMOs, PPOs, but also employers and the United States government.

Other circuits have held that state laws directed at regulation of broadly defined health benefit plans, only some of which fall within the insurance industry, do not regulate insurance within the meaning of the savings clause. *Prudential Ins. v. National Park Med. Ctr.*, 154 F.3d 812 (8th Cir. 1998) (holding Arkansas Patient Protection Act applied to broadly defined health plans which included insurers was not saved despite specific exclusion for self-funded plans), *Cigna Health Plan of La., Inc. v. Louisiana*, 82 F.3d 642, 649 (5th Cir. 1996) (concluding that the statute was not saved as an insurance regulation because it was not limited to entities in the insurance industry as it applied to entities such as self-funded organizations, Taft-Hartley Trusts, or employers who establish and participate in self-funded trusts or programs as well as various intermediaries); *Blue Cross & Blue Shield of Alabama v. Neilsen*, 917 F. Supp. 1532, 1538-39 (N.D. Ala. 1996) (holding that Alabama's 'any willing provider' statutes did not regulate insurance as a matter of common sense because they applied to all employee benefit plans including

self-funded plans, and were thus not specifically directed toward the insurance industry) (vacated in part on appeal by *Blue Cross & Blue Shield of Alabama v. Neilsen*, 142 F.3d 1375 (11th Cir. 1998) due to mootness after the Alabama Supreme Court determined in a certified question that the law at issue did not apply to plaintiff).

The federal courts have addressed the scope of ERISA's preemption of state law on numerous occasions, however, the wording of the Act combined with the obvious federalism concerns involved have made it difficult to discern clear boundaries. Many courts, including this Court, have commented on the broad and ambiguous nature of the provisions.[1] Contributing to such interpretational difficulties is the instant lower court opinion broadening the scope of the savings clause. The lower court's rationale in determining the subject state law regulates insurance within the meaning of the savings clause, conflicts with holdings of this Court and other circuits.

I. The Decision Below Focused On The Funding Of The Plan As The Determinative Issue For ERISA Preemption, Rather Than Addressing The Issue At Hand, Which Was Whether The Subject State Law Regulates Insurance Within The Meaning Of The Savings Clause.

The lower court's opinion devotes most of its ERISA preemption analysis to whether the deemer clause overrides the

1. *See, e.g., California Div. Of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 335-36, 117 S. Ct. 832, 843, 136 L. Ed. 2d 791, 805-06 (1997) (Scalia, J., concurring) (noting that the Court had taken 14 previous cases regarding ERISA preemption, and suggesting that neither the Court's prior decisions, nor its present one, succeeded in bringing clarity to the law); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656, 115 S. Ct. 1671, 1677, 131 L. Ed. 2d 695, 705 (1995) (remarking on the unhelpful nature of the statute's text and the frustrating difficulty of defining its key terms).

savings clause when a self-funded plan is not at issue. (Apx. A, pgs. 22a-25a). This focus is nonsensical. Because this case did not involve a self-funded plan, the deemer clause was never at issue. Nonetheless, AAA Michigan argued the state law was not preempted because the ERISA plan was not self-funded. The Sixth Circuit adopted AAA Michigan's position and by doing so, failed to follow the holdings of this Court and other circuits.

The focus of the lower court on the funding of the plan as the determinative issue for ERISA preemption is inconsistent with this Court's decisions. In *Unum Life Ins. Co. v. Ward*, 526 U.S. 358, 119 S. Ct. 1380 (1999), this Court addressed the identical issue AMS raised in the proceedings below: Does the [subject state law] "regulat[e] insurance" and thus escape preemption under the savings clause, § 514(b)(2)(A). *Id.* at 1386. This Court noted in a footnote "[b]ecause this case does not involve a self-insured plan, [the] limitation on state regulatory authority [resulting from the deemer clause] is not at issue here." *Id.* As a result of the lower court's misplaced focus on the plan's funding, it failed to address the state law at issue.

The subject state law is an amalgamation of statute, case law, politics and practice. The state priority rule is based upon a provision in the Michigan No-Fault Automobile Insurance Act, MCLA § 500.3109a, which was subsequently construed by the Michigan Supreme Court to apply to all entities which provide medical expense coverage, and then later overruled in part, to exclude employee welfare benefit plans. Since the subject state law is what must be analyzed, a brief overview of the priority rule appears helpful.

In theory, under Michigan's No-Fault Act, individuals injured in an automobile accident will have medical expense coverage for their injuries. For the most part, the Act provides for unlimited medical expense coverage and thus, the corresponding costs are high. The no-fault automobile insurers often complain about these costs, yet it should also be pointed

out that the no-fault automobile insurers do have a guaranteed market, establish their own premiums, and provide a huge political force in the State.

An example of the favorable treatment of the no-fault automobile insurers is the Federal Kemper rule. The No-Fault Act does require the no-fault automobile insurers to offer coordinated coverage at a reduced premium. MCLA § 500.3109a. It should be noted that § 3109a does not use any quantitative term such as "substantially" reduced premium, and in fact, the reduction of premium is typically quite nominal. Nonetheless as a result of this statutory requirement, the Michigan Supreme Court developed a priority of coverage rule such that when there is a priority dispute between a no-fault automobile insurer which has issued a coordinated policy under § 3109a and an accident victim's other health coverage provider, where both include conflicting coordination of benefits provisions, the other health coverage provider will be deemed primary. *Federal Kemper Insurance Co., Inc. v. Health Insurance Administration, Inc., supra.*

The State priority rule was first invoked to pass the costs of medical expenses incurred in an automobile accident from the accident victim's automobile insurer to his employer. The priority rule was not aimed at insurers or the insurance industry. The priority rule was instead a manner to protect the no-fault automobile insurers from paying claims when the accident victim had coordinated coverage with another source, including employers, the government, or any health plan or policy.

It is undisputed the court's ruling in *Federal Kemper* was never limited to insurance. Indeed, the court specifically used the phrase "coverage," instead of "insurance" to encompass much more than just insurance. Michigan courts have expressly held that the Michigan Supreme Court's use of the term

"coverage" rather than "insurance" in *Federal Kemper*, militates against a restrictive reading of the rule. *See Nyquist v. Aetna Ins. Co.*, 84 Mich. App. 589, 269 N.W.2d 687 (1978) (Blue Cross-Blue Shield benefits were held subject to coordination under the priority rule even though Blue Cross-Blue Shield benefits were held not to be insurance; *Perez v. State Farm Ins. Co.*, 418 Mich. 634, 344 N.W.2d 773 (1984) (the coordination sought was with respect to "unavailable benefits" as the employer had no workmen's compensation insurance; *Tousignant v. Allstate Ins. Co.*, 444 Mich. 301, 506 N.W.2d 844 (1992) (the rule applies to a Health Maintenance Organization (HMO)), *Owens v. ACIA*, 444 Mich 314, 506 N.W.2d 850 (1943) (the Veterans Administration and United States military forces included coverages to be coordinated).

The Michigan Supreme Court revisited the application of the priority rule in *ACIA v. Frederick & Herrud, Inc.*, 443 Mich. 358 (1993). The court recognized the actual context in which the Federal Kemper rule was rooted, involved a conflict between a no-fault automobile insurer and an ERISA plan:

> In *Federal Kemper*, this Court reached the conclusion that the health insurance provider was primarily responsible for payments without considering ERISA preemption although it appears that the defendant plan was an ERISA plan. However, at the time Federal Kemper was decided, the federal position on state regulation of insurance law had long been one of deference to state expertise. While the United States Supreme Court and the Sixth Circuit Court of Appeals have recently concluded that the conflict involved here is to be determined by the federal common law, exactly what that law should be is the subject of differing interpretations between the two federal district courts in this state.

Id. at 384.

In *Frederick & Herrud*, the Michigan Supreme Court went on to hold the Federal Kemper rule would have a direct rather than an indirect effect on ERISA plans, and thus the state priority rule was preempted by ERISA. The court presaged the Sixth Circuit and held under federal law, the automobile insurance was the primary source of recovery:

> We hold that an unambiguous [coordination of benefits] clause in an ERISA health and welfare benefit plan must be given its plain meaning despite the existence of a similar clause in a no-fault policy because any conflict created by [the Federal Kemper rule] would have the direct effect of dictating the terms of the ERISA plans. To the extent that our decision in *Federal Kemper* is inconsistent with our holding today,[2] it is overruled.

Id. at 389-90.

In *Auto Owners Ins. Co. v. Thorn Apple Valley, Inc.*, 31 F.3d 371 (6th Cir. 1994), *cert. denied*, 513 U.S. 1184, 115 S. Ct. 1177, 130 L. Ed. 2d 1129 (1995), the Sixth Circuit set forth the federal priority rule, which is directly contrary to the state priority rule. Under the federal priority rule, when an ERISA plan and a Michigan no-fault automobile insurance policy have conflicting coordination of benefits provisions where each provide the other is primary, then the terms of the ERISA plan must be given full effect.

It should be noted that the federal priority rule was developed in a case involving a self-funded plan. In cases involving self-funded plans, the importance of the savings clause analysis is diminished because even if the law is saved, it will not reach self-funded plans. *FMC v. Holliday*, 498 U.S. 52, 111

2. The lower court stated this holding overruled *Federal Kemper* only to the extent self-funded plans were involved, however, the Michigan Supreme Court's holding appears to apply to "ERISA health & welfare benefit plans." *Id.* Arguably, the holding includes both insured and self-funded plans.

S. Ct. 403, 112 L. Ed. 2d 356 (1990). As a result of clear ERISA preemption, a gap was left in how to resolve the conflict as a matter of federal law. Both the Michigan Supreme Court and the Sixth Circuit held the conflict was resolved by giving full effect to the terms of the ERISA plans.

Given the conflicting state and federal priority rule, the issue in the instant case is whether the state priority rule is saved from ERISA preemption with respect to insured ERISA plans. Because the plans are insured, the savings clause analysis is critical. Here, if the state priority rule is not "saved," then the federal priority rule applies and AAA Michigan is primary.

Reversal of the substantive issue will also affect the lower court's decision in "Case No. 98-1973 - Coan and Williamson" with respect to the one-year limitation period. The lower court distinguished *NALC Health Benefits Plan v. Lunsford*, 879 F. Supp. 760 (E.D. Mich. 1995) which held the one-year limitation period could not prevent an insured from recovering no-fault automobile insurance benefits in circumstances involving a federal reimbursement statute which preempted state law. Here, if ERISA preempts the state priority rule, then under the federal law, AMS is entitled to reimbursement of the medical expenses and AAA Michigan can not invoke the one-year back rule to avoid paying the benefits owed to its insureds.

This Court has provided a framework for resolving whether a state law "regulates insurance" within the meaning of the saving clause. *Unum*, *supra* at 1386; *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 50, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987). First, the state law is analyzed under the common-sense view of the savings clause. *Id.* Second, the court considers three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C. § 1011, *et seq.*: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is

limited to entities within the insurance industry." *Metropolitan Life Ins Co. v Massachusetts*, 471 U.S. 724, 743, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985); *see also Pilot Life*, 481 U.S. at 48-49.

II. Certiorari Is Warranted Because The Decision Below Conflicts With Decisions Of This Court And Of Other Circuits.

The lower court's decision is inconsistent with this Court's opinions addressing a savings clause analysis. There is no dispute the subject state law "relate[s] to" employee benefit plans and falls under ERISA's preemption clause, § 514(a). (Apx. A, pg. 19a). Thus, the dispute hinges on the question: Does the state priority rule "regulat[e] insurance" and thus escape preemption under the savings clause, § 514(b)(2)(A). Because this case does not involve a self-insured plan, the limitation on state regulatory authority resulting from the deemer clause is not at issue here.

Despite AMS' efforts to address the state priority rule under the savings clause analysis promulgated by this Court, the Sixth Circuit provided very little analysis on this critical issue. The Sixth Circuit's analysis is set forth in one paragraph of the opinion wherein the court states it has already spoken on the issue:

> As applied to § 3109a, this Court has already spoken as to whether this provision regulates insurance for purposes of the savings clause. Specifically, in *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, this Court had occasion to determine whether § 3109a was preempted under ERISA under the jurisprudential principles noted above, and found as follows:
>
> > [T]he Michigan coordination of benefits law controls the terms of the insurance contracts. The Michigan law clearly "regulates insurance" within the meaning

> of the savings clause. This conclusion comports both with a common sense view of the statutory language and with a more formal assessment that the practice falls within the meaning of "business of insurance" covered by the McCarran-Ferguson Act.
>
> 833 F.2d 85, 89-90 (6th Cir. 1987). The Court went on to determine that the deemer clause did not override the savings clause as applied to § 3109a, even when the plan at issue was self-funded. *Northern Group Services* at 95.

Id. (Apx. A at pg. 20a). Although the lower court states the issue was addressed conclusively, a review of *Northern Group Services*, reveals the above conclusions were made with little or no analysis, and the rationale is inconsistent with this Court's opinions addressing a savings clause analysis. Indeed, the state priority rule does not control the terms of insurance contracts since insurers are entitled to include coordination of benefits provisions in their contracts. The conflict which results when insurers and other entities include such provisions is the subject of the priority rule. Thus, the lower court held the state law, although not aimed at insurers and insurance contracts, was nonetheless saved, because the state law was "principally" directed toward insurance-type entities, which is inconsistent with the holdings of this Court and other circuits.

A. The Decision Below Conflicts With The Holding Of This Court And Other Circuits Which Conclude A State Law Must Have Not Merely An Impact On The Insurance Industry, But Must Be Specifically Directed Toward That Industry To Regulate Insurance Within The Meaning Of The Savings Clause As A Matter Of Common Sense.

In order to satisfy a common sense understanding of the phrase "regulates insurance," a state law must have not merely

an impact on the insurance industry, but must be specifically directed toward that industry. *Pilot Life*, *supra*. In *Unum*, *supra*, this Court found California's notice-prejudice rule satisfied the common-sense view as a regulation that homes in on the insurance industry and does not just have an impact on [that] industry. 119 S. Ct. at 1387 (quoting *Pilot Life*, 481 U.S., at 50, 107 S. Ct. 1549.) Indeed, the Court noted that a survey of California law revealed no case where the notice-prejudice rule was applied outside the insurance area. *Id.*

In *Northern Group*, the Sixth Circuit acknowledged that the subject state law was applied to other entities which were not insurers and other plans which were not insurance contracts, but nonetheless stated:

> The Michigan coordination of benefits law obviously is principally directed at various types of other-insurance coverage held by all of its residents who elect the coordination of benefits option that is mandated by § 3109a. Mich. Comp. Laws § 500.3109a.

Northern Group, 833 F.2d at 659. The Sixth Circuit broadened the scope of the savings clause to include state laws "principally directed" at various types of coverage providers. The decision below is inconsistent with holdings of this Court and other circuits which conclude the subject state law must be specifically directed toward insurers and insurance contracts.

Presumably each time courts are called upon to address whether a state law regulates insurance within the meaning of the savings clause, the state law is going to involve or have an impact on insurance otherwise the savings clause would not be implicated. Thus, the analysis requires more than a determination as to whether the law may apply to or otherwise affect insurance companies, the analysis requires a determination as to whether the law actually regulates the business of insurance within the meaning of the savings clause under 29 U.S.C. § 1144(b)(2)(A).

Here, the state priority rule does not merely regulate the conduct or policies of insurance companies, rather, the state priority rule purports to regulate the terms of all health coverage plans, irrespective of whether the plans are funded through insurance. It is because of its broad reach that the Michigan Supreme Court concluded the state priority rule, "would have the direct effect of dictating the terms of the ERISA plans." *ACIA v. Frederick & Herrud*, *supra* at 389-90.

In *Prudential Ins. v. National Park Med. Ctr.*, 154 F.3d 812 (8th Cir. 1998), the court found that a state law that was part of the Arkansas Insurance Code applicable to "health care insurers" as defined by the act was preempted even though the statute under consideration expressly excluded "self-funded or other health benefit plans that are exempt from state regulations by virtue of the federal [ERISA]." *Id.* at 816. The statute in question, the Arkansas Patient Protection Act, prohibited a "health care insurer" from imposing a monetary advantage or penalty that would affect the patients choice of health care providers, prohibited insurers from providing for unequal co-payments, fees or conditions for participating providers and prohibited insurers from limiting a provider's ability to participate under a plan. Ark. Code Ann. § 23-99-204. *Id.*

The Eighth Circuit found that the statute defined the term "health care insurer" to include entities other than insurance companies and held that the law could not be saved despite its attempt to exclude self-funded plans from its application:

> Contrary to appellants' assertions, we conclude that the district court correctly held that the Arkansas PPA is not "saved" from preemption by the ERISA savings clause. First, the Arkansas PPA is not a state law that "regulates insurance" under a common sense approach, *Metropolitan Life Ins. Co.*, 471 U.S. at 740, because it is not a law that is "specifically directed toward that industry." *Pilot Life Ins. Co.*, 481 U.S. at 50; *United of Omaha*, 104 F.3d at 1039.

Id. at 829. In fact, the law at issue in that case, like the state priority rule, was:

> not a law directed at the insurance industry at all, but a law directed at regulation of broadly defined health benefit plans, only some of which fall within the insurance industry.

Id. Thus, because the Arkansas law reached both insured plans and plans that were beyond the insurance industry, it failed to meet this Court's test and was preempted as to all plans, notwithstanding the express exclusion in the law for self-funded ERISA plans.

In *Hayden v. Blue Cross and Blue Shield of Alabama*, 843 F. Supp. 1427 (M.D. Ala., 1994), the court concluded that a state law requiring direct payment to certified registered nurse anesthetists for services rendered to patients who have a contract or plan of health insurance, or any plan or agreement for health care services, is not a law "regulating insurance" within the meaning of ERISA's savings clause. The court held the law in question failed to meet the common sense meaning of the phrase "regulates," as the law was not specifically directed toward the insurance industry. *Id.* at 1434. The court recognized that the law would have a substantial effect on the insurance industry, but noted that it would affect other health plans and agreements even though they are not part of an insurance agreement and thus, concluded that the law failed the first tier of the savings clause analysis and did not survive preemption. *Id.* at 1434.

Likewise the subject state priority rule is not limited to the insurance industry alone and has never been construed to be limited to insurance. The statute uses the term "other health coverage" and, subsequent to *Northern Group*, *supra*, the Michigan Supreme Court construed Section 3109a to be so all-encompassing that it even reaches medical expenses and medical services that the Veterans Administration or United States military forces are required to either pay for or provide to a member of the United States Coast Guard under federal law. *Owens v. ACIA*, 444 Mich. 314, 506 N.W.2d 850 (1993).

Given this application of the state priority rule, the argument that the priority rule is specifically directed toward the insurance industry cannot be plausibly maintained. Thus, although the subject state law may have a substantial affect on the insurance industry, because the priority rule applies to health plans offered by non-insurers and to health services provided directly by the military or Veterans Administration under federal law, such a law does not fall within the savings clause.

The decision below conflicts with the holdings of this Court and other circuits which conclude a state law does not satisfy the common-sense view of a law which regulates insurance within the meaning of the savings clause when it merely has an impact on insurers and insurance contracts.

B. The Decision Below Conflicts With The Holding Of This Court And Other Circuits' Application Of The McCarran-Ferguson Criteria.

The lower court provided no analysis with respect to the three factors employed to determine whether the regulation fits within "the business of insurance" as that phrase is used in the McCarran-Ferguson Act. 15 U.S.C. § 1011, *et seq*:

> [*F*]*irst*, whether the practice has the effect of transferring or spreading the policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Unum, 119 S. Ct. 1380, 1386 (1999)

In *Unum*, *supra*, this Court stated the McCarran-Ferguson factors are considerations to be weighed, and none is necessarily determinative in itself. *Id.* at 1383. Nonetheless, the lower court again with no discussion and relying upon the dicta in *Northern Group*, *supra*, concluded that the first two criterion were met. *Id.* at 90. The Sixth Circuit did acknowledge the third criterion was not met.

In *Northern Group*, the Sixth Circuit concluded:

> . . . we find the first two of the three criteria easily satisfied. The practice of coordination of benefits spreads risk and regulates permissible terms of the insurance contract.

Id. at 90. The lower court's conclusion with respect to the first two criteria is inconsistent with holdings of this Court and other circuits.

1. The State Priority Rule Does Not Affect The Allocation Of Risk For Which The Policyholders Initially Contracted.

The first McCarran-Ferguson "risk-spreading" factor involves the allocation of risk for which the parties initially contracted. *Unum*, *supra* at 1389. Here, rather than shifting risk from policyholders to insurers, the state priority rule merely addresses the priority of coverage amongst entities which already provide coverage. The risk assumed by the benefit plan under its policy, that the policyholder will require medical treatment, remains unaltered. Likewise, the risk assumed by the no-fault automobile insurer under its policy, that the policyholder will incur medical expenses in an automobile accident also remains unaltered.

This Court discussed the transfer of policyholder risk in detail in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979). The Court was considering whether agreements between Blue Shield and participating pharmacies concerning the price that policyholders would pay for prescriptions, constituted the business of insurance. Under the agreements, the participating pharmacies would fill any Blue Shield policyholder's prescription for a two-dollar charge. *Id.* at 209, 99 S. Ct. at 1072. The pharmacy was then entitled to reimbursement from Blue Shield for the cost of acquiring the drugs prescribed. *Id.* This Court found that, under the antitrust exemption provision of the McCarran-Ferguson

Act, 15 U.S.C. § 1012(b), the arrangement did not constitute the "business of insurance" because Blue Shield's agreement with the pharmacies merely limited the amount that it would have to pay to cover its policyholder risks. *Id.*

Similarly, the state priority rule has almost no effect on the policyholder's risk that insurers must underwrite. Like Blue Shield's unchanged obligation to cover a policyholder's prescriptions after entering into the pharmacy agreements, AMS and AAA Michigan must cover the same medical procedures irrespective of the priority rule. The state priority rule does not alter the type of policyholder risks — that insureds will incur medical expenses in automobile accidents or that employees/ beneficiaries will incur medical expenses.

The Michigan Federal Kemper rule applies to health plans and health services that have nothing to do with insurance or insurance policies at all. Hence, is cannot be said to simply spread policyholders' risks.

2. The State Priority Rule Does Not Affect An Integral Part Of The Policy Relationship Between The Insurer And Insured.

Under the second McCarran-Ferguson factor, a state law is analyzed as to whether it affects an integral part of the policy relationship between the insurer and insured. Here, the state priority rule leaves the policy relationship between the insurer and insured unaltered. The relationships directly affected by the law are those existing between insurers and other coverage providers. As discussed above, the medical risks covered by the policies or plans remain the same.

Although the Sixth Circuit provided no analysis of these factors, AAA Michigan argued below that the priority rule is an integral part of the policy relationship between the insurer and the insured because it "effectively creates a mandatory contract term." *Unum*, 119 S. Ct. at 1389. However, unlike the mandatory notice-prejudice rule in *Unum*, the state priority of

coverage rule does not force the insurer to offer a benefit to insureds that was not otherwise available.

In *Unum*, this Court observed California's notice-prejudice rule changes the bargain between insurer and insured by effectively creating a mandatory contract term that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision. In contrast, AAA Michigan must offer coordinated coverage to its insureds at a reduced premium irrespective of the priority rule. In the event its insureds do not have other health coverage, AAA Michigan is contractually obligated to pay its insured's medical expenses and this bargain is not changed by the subject state law.

Likewise the ERISA plans are allowed to coordinate benefits. The plans funded by insurance policies are subject to the state insurance laws which do not preclude the inclusion of such provisions. The priority rules address the situation where the valid coordination of benefits provisions in the plans and policies conflict. This is not an integral part of the relationship between the policyholders and the insurers, it resolves conflicts between coverage providers.

3. The State Priority Rule Is Not Limited To Entities Within The Insurance Industry.

It is undisputed the subject state law is not limited to entities within the insurance industry and does not meet the third McCarran-Ferguson criterion. As discussed above, the priority rule addresses all health and medical "coverage" irrespective of whether that coverage is provided by way of insurance or otherwise. It applies to coverage afforded by way of direct services rendered by the VA or medical expenses paid by the military forces pursuant to federal law.

In *Nyquist*, *supra*, the court found that health care benefits were subject to coordination under Section 3109a even though the benefits in question were issued by Blue Cross-Blue Shield, an entity which is not an insurer under Michigan law and is not

regulated under the laws applicable to health insurance companies. The appellant in that case argued that Section 3109a was limited to insurance and that, because Blue-Cross Blue Shield benefits are not insurance, Section 3109a did not apply. The court specifically noted that *Federal Kemper* used the term "coverage" rather than "insurance" which it held militates against the restrictive reading of the statute.

In *Perez*, *supra*, the coordination sought was with respect to "unavailable benefits," i.e. the statute was held to reach an employer who had not procured workers compensation insurance. Thus, even though the employer in that case was not an insurance company, the *Federal Kemper* rule was held to apply.

III. The Subject State Law Is Not A Law Which Regulates Insurance Within The Meaning Of ERISA's Savings Clause, And Thus Is Preempted By ERISA.

The lower court's holding that states are free to regulate ERISA plans insofar as the plans are "insured," is inconsistent with the holding of this Court and other circuits. This Court has held state laws that directly regulate ERISA plans are preempted, but state laws which indirectly regulate plans by directly regulating insurers and insurance contracts are saved. *FMC Corp v. Holliday*, 498 U.S. 52, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990).

In *Lincoln Mutual Casualty Co. v. Lectron Products, inc., Employee Health Benefit Plan*, 970 F.2d 206 (6th Cir., 1992), the Sixth Circuit addressed the argument that AAA Michigan asserted in the instant case and reached a different conclusion. Here, AAA Michigan argued that because the plan was not self-funded, ERISA did not apply. It appears the lower court contradicted *Lincoln Mutual*, and agreed with AAA Michigan's position that because the plan was insured, the state law was not saved, stating: "Simply put, *Lincoln Mutual* held that because the ERISA plan was self-funded, Michigan's no-fault laws were preempted." (Apx. A, pg. 23a).

The above quote appears misplaced. In *Lincoln Mutual*, the employee benefit plan was self-funded for the first $75,000, however, the employer had purchased stop-loss catastrophic claims coverage for claims above $75,000. It was undisputed that the deemer clause applied to the first $75,000. It was this portion of the opinion which the lower court cited. (Apx. A, pg. 23a). However, in *Lincoln Mutual*, the court went on to address the portion of the plan that was "insured". *Id.* at 210.

Lincoln Mutual argued that for claims above $75,000, the Plan was "insured," and therefore under *FMC*, *supra*, was subject to regulation by the state. *Id.* at 210. Thus, Lincoln Mutual put the instant issue before the court and argued that ERISA does not preempt the subject state law to the extent the plan is "insured." *Id.*

Addressing the identical argument advanced by AAA in the court below, the Sixth Circuit found the argument without merit and held:

> We conclude that [the no-fault insurer's] contention is without merit. As the *FMC* Court instructs us, "if a plan is insured, a State may regulate it *indirectly through regulation of its insurer and its insurer's insurance contracts.*" __ U.S. at __, 111 S.Ct. at 411. Because Mich. Comp. Laws 500.3109a and Michigan case law interpreting 3109a , see *Federal Kemper Ins. Co. v. Health Ins. Admin., Inc.*, 424 Mich 537; 383 NW2d 590 (1986), would *directly* regulate the Plan under the circumstances of the instant case, ERISA preempts the application of Michigan law.

Lincoln Mutual, *supra* at 210. (Emphasis in original)

The court specifically stated that states may not regulate ERISA plans insofar as the plans are insured, rather, the inquiry under *FMC*, is whether the subject state law would *directly* regulate the ERISA plans (through indirect regulation of insurers

and insurance contracts). *Id.* State regulation may have an incidental, or "indirect" effect on ERISA plans, but if the state law *directly* regulated the ERISA plans, it does not survive ERISA preemption. The subject state law would *directly* regulate ERISA plans. Oddly, the lower court distinguished *Lincoln Mutual* in the instant case and thus the instant opinion appears to be inconsistent with *FMC, supra.*

This Court's holding in *FMC, supra*, with respect to direct and indirect regulation was also addressed by the Michigan Supreme Court in *ACIA v. Frederick & Herrud, supra* at 383. First the court recognized that if a state law affects an ERISA plan, the only way it can be saved is if it indirectly regulates the plan by regulating the business of insurance:

> The only qualifier to ERISA preemption of state insurance law is indirect regulation via state laws governing insurance companies that assume plan liability in exchange for premiums paid by an ERISA plan. *FMC Corp., supra.* at 61.

Frederick & Herrud, supra at 383

Having determined the only qualifier to ERISA preemption of state insurance law is indirect regulation (via state laws governing insurance companies and contracts), the Michigan Supreme Court addressed whether its interpretation of Section 3109a in *Federal Kemper* was a direct or indirect regulation of employee welfare benefit plans. If "direct," ERISA preempted the state law as construed in *Federal Kemper*. If "indirect," the state law regulating insurance would be "saved" under ERISA's savings clause. The Court concluded that the law is not saved:

> [a]lthough the Michigan statute purports to regulate insurance and not ERISA plans, we conclude that it has a *direct* effect on the administration of the plans in these cases because it would virtually write a primacy of coverage clause into the plans.

Frederick & Herrud, supra at 387.

Having concluded that its interpretation of Section 3109a under *Federal Kemper* would constitute direct regulation of employee benefit plans, the subject law was held to be preempted by ERISA:

> we hold that an unambiguous COB clause in an ERISA health and welfare benefit plan must be given its plain meaning despite the existence of a similar clause in a no-fault policy because any conflict created by the requirements of MCL § 500.3109a; MSA § 24.13109(1) and this Court's interpretation of the statute would have the *direct* effect of dictating the terms of the ERISA plans. To the extent that our decision in *Federal Kemper* is inconsistent with our holding today, it is overruled.

Frederick & Herrud, *supra* at 389-90.

The lower court distinguished these cases holding that to the extent the subject ERISA plans are insured, the priority rule "indirectly" dictates the terms of the plan. This holding is inconsistent with *FMC*, *supra*. This same inconsistent analysis was provided in *American Medical Security, Inc. v. Allstate Ins. Co.*, *supra* (*"Perri"*). In *Perri*, the no-fault insurer argued that ERISA (the entire federal statute) only applies to self-funded employee benefit plans. The court agreed that because the plan "was not self-funded," the subject state law was not preempted. This rationale simply guts the savings clause. (In *Pilot Life*, *supra*, the plan was "not self-funded," yet this Court nonetheless found the state laws involved in that case were preempted as they did not "regulate insurance" within the meaning of ERISA's savings clause).

The *Perri* court turned the preemption analysis upside down and reasoned if a plan is "not self-funded," a state law is saved. It contradicted the Sixth Circuit and the Michigan Supreme Court which found application of the subject state law would *directly* affect ERISA plans and stated:

> [t]he employee benefit plan at issue was not a self-funded plan, and plaintiff's insurer, United Wisconsin, was subject to Michigan insurance law and regulation, specifically § 3109a, even where that statute indirectly affects the plan. Our ruling does not allow our state law to control an ERISA plan, but simply recognizes that state law can regulate the insurer of an ERISA plan even if that regulation may indirectly affect the plan, which is the case here.

Id. at 307. Thus, the *Perri* court completely contradicted *Lincoln Mutual*, *supra.*, and *Frederick & Herrud*, which held the same state law would directly affect an employee welfare benefit plan.

ERISA preempts the subject state priority rule as it "relates to" the subject ERISA plans and does not "regulate insurance" within the meaning of ERISA's savings clause. The subject state priority rule has been repeatedly construed to reach not only insured plans, but any health coverage irrespective of how that coverage is provided. It is directed at entities which include branches of the United States military, uninsured employers, and direct health care providers. Given its reach, the state priority rule does not "regulate insurance" within the meaning of the savings clause and thus does not survive preemption.

Because the state priority rule is preempted by ERISA, resolution of the conflicting coordination of benefits provisions should be decided under federal law. Under federal law, the terms of the ERISA plans must be given full effect. *Thorn Apple Valley*, *supra* at 375. Giving full effect to the Excess Coverage provisions of the subject ERISA plans, AAA is primarily liable for the subject medical expenses of Coan, Williamson and Teagan. The Sixth Circuit's decision to the contrary impermissibly broadens the scope of the savings clause and conflicts with the decisions of this Court and of other circuit court of appeals, further pointing to the need for review by this Court.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION AND JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT DATED, DECIDED AND FILED JANUARY 4, 2001

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

Nos. 98-1973; 99-2110

AMERICAN MEDICAL SECURITY, INC.,

Plaintiff-Appellant,

v.

AUTO CLUB INSURANCE ASSOCIATION OF MICHIGAN,

Defendant-Appellee.

Appeal from the United States District Court
for the Eastern District of Michigan at Detroit.
No. 97-75632 — Avern Cohn, District Judge.

Argued: October 25, 2000

Decided and Filed: January 4, 2001

Before: DAUGHTREY and CLAY, Circuit Judges;
RUSSELL, District Judge.*

* * *

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* The Honorable Thomas B. Russell, United States District Judge for the Western District of Kentucky, sitting by designation.

Appendix A

OPINION

CLAY, Circuit Judge. This is a consolidated appeal wherein Plaintiff, American Medical Security Inc. ("AMS"), appeals from two separate judgments entered by the United States District Court for the Eastern District of Michigan granting summary judgment to Defendant, Auto Club Insurance Association of Michigan ("AAA"), while denying summary judgment to Plaintiff, regarding Plaintiff's claims involving payment of benefits.

Specifically, in **Case No. 98-1973,** Plaintiff appeals from the district court's judgment entered on August 4, 1998, granting summary judgment to Defendant as to the claims for reimbursement pursued by Plaintiff as subrogee to Peter C. Coan and Jerry Williamson. The district court found that as a matter of law, Plaintiff's suit was time barred by the "one-year back" rule under Michigan's No Fault Insurance Act, Mich. Comp. Laws Ann. § 500.3145. In **Case No. 99-2110,** Plaintiff appeals from the district court's judgment entered on September 9, 1999, granting summary judgment to Defendant as to the claim for reimbursement pursued by Plaintiff as subrogee to Andrea Teagan. The district court found that the relevant Michigan statute was not preempted by the Employment Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a); that Michigan's No Fault Act therefore applied; and that under Michigan's "*Federal Kemper*" rule, Plaintiff was the primary insurer.

By order of this Court, the two cases, which were heard before the same district judge, were consolidated on appeal, and we now **AFFIRM** the district court's judgment in both

cases. We have jurisdiction over the matter pursuant to 28 U.S.C. § 1331, inasmuch as Plaintiff's claims arose under 29 U.S.C. § 1132(a)(1)(B) of ERISA.

BACKGROUND

This case involves a dispute over which of two potential insurance providers — Plaintiff, American Medical Security, Inc., which is the third-party administrator of ERISA-governed employee welfare benefit plans; or Defendant, Automobile Club Insurance Association, which is a Michigan no-fault automobile insurer — is responsible for the payment of medical expenses paid on behalf of three individuals for injuries that they received when each was involved in separate automobile accidents. The facts relevant to each case are as follows.

A. Case No. 98-1973

On April 26, 1992, Peter C. Coan was injured in an automobile accident. At the time of the accident, Coan was employed by Daniels Glass Co., Inc., and was a participant in its employee benefit plan. Plaintiff, the third-party administrator of the plan, paid out $197,857.85 for medical expenses Coan incurred as a result of the automobile accident.

On April 13, 1993, Jerry Williamson was injured in an automobile accident. At the time of the accident, Williamson worked for C&M Masonry and was a participant in its employee benefit plan. Plaintiff was the third party administrator of the plan and paid out $8,239.38 for medical expenses that Williamson incurred as a result of the accident.

Appendix A

At the time of the accidents, Coan and Williamson each had a valid policy of no-fault insurance with Defendant AAA that included a provision for coordinated coverage. The provision provided as follows:

> If the Declaration Certificate shows "COORDINATED MEDICAL BENEFITS," it is agreed that all other medical insurance or health care benefit plans available to you . . . are your primary source of protection.

(J.A. at 409, 435.) The subject Certificates of Group Insurance administered by Plaintiff AMS provide excess coverage as follows:

> **EXCESS COVERAGE**
> No benefits are payable for Injury or Sickness for which there is other insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent. If We make payment on Your behalf, You agree to assign to Us any right You have against the other insurer.

(J.A. at 97, 161, 579, 612, 637.)

Plaintiff sought reimbursement from Defendant for the medical expenses that it had paid out on behalf of Coan in a letter dated December 29, 1995. After Defendant orally invoked the "one-year back" rule of Michigan's No Fault Act, Mich. Comp. Laws Ann. § 500.3145, to deny Plaintiff's request, Plaintiff sent another letter to Defendant dated November 15, 1996, again requesting reimbursement.

Thereafter, in a letter dated February 26, 1997, Defendant reiterated its earlier denial of Plaintiff's request once again citing the "one-year back" rule as the basis for doing so.

As a result of Defendant's denial of Plaintiff's requests for reimbursement, Plaintiff filed suit against Defendant on November 12, 1997, in the United States District Court for the Eastern District of Michigan. On April 27, 1998, Plaintiff filed a motion for summary judgment; on May 27, 1998, Defendant filed an answer to Plaintiff's motion for summary judgment in the nature of a cross-motion for summary judgment. Thereafter, on August 4, 1998, the district court issued a Memorandum and Order wherein the court concluded that the "one-year back" rule was applicable based upon the Michigan Supreme Court's decision in *Auto Club Insurance Association v. New York Life Ins. Co.*, 485 N.W.2d 695 (Mich. 1992). Accordingly, the court denied Plaintiff's motion for summary judgment while granting Defendant's cross-motion for summary judgment. The court opined in relevant part as follows:

> The logical extension of *New York Life* is that (1) when AMS [Plaintiff] sued AAA [Defendant] for reimbursement, arguing that it was secondarily liable, it essentially asserted subrogation; (2) AMS is therefore subrogated to the claims of Coan and Williamson; and (3) AMS must therefore abide by the one-year back rule, which limits Coan and Williamson's right to recovery. Because AMS sought reimbursement more than one year after the most recent allowable expenses, it cannot now bring these claims against AAA.

(J.A. at 471.)

Appendix A

B. Case No. 99-2110

On July 8, 1994, Andrea Teagan was injured in an automobile accident. Andrea is the daughter of Lillian Tull and, at the time of her accident, Andrea was covered under her mother's employee benefit plan sponsored by Temp West, Inc. Plaintiff was the third-party administrator of the plan.

Effective May 25, 1992, and through the date of the accident, Defendant insured Tull under an automobile policy which provided coordinated no-fault medical coverage to Tull and Andrea. Shortly after the July 8, 1994, accident, Tull informed Defendant that Andrea was covered by Tull's ERISA health insurance plan administered by Plaintiff. On July 22, 1994, Defendant verified with Plaintiff that Tull's health insurance was in effect and covered Andrea.

By way of letter dated July 28, 1994, Defendant informed Tull that because she had purchased coordinated medical benefits coverage from Defendant, she was required to submit all medical bills to her health and accident insurer first; that Defendant would consider payment of expenses which her health and accident insurer rejected; and that Tull had one year from the date of any medical treatment to submit bills to Defendant. Between July 8, 1994 and July 31, 1996, Plaintiff paid out $174,282.51 to cover the cost of the medical expenses incurred by Andrea as a result of the accident.

In a letter dated February 27, 1995, from Plaintiff's subrogation recovery vendor, Thomas Wilkes, Plaintiff requested reimbursement from Defendant for the amounts paid out on behalf of Andrea. Specifically, the letter provided in part as follows:

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> Please be advised that we are the authorized subrogation recovery vendor for American Medical Security Insurance Company in regards to the above-captioned insured, Andrea Teagan.
>
> Our subrogation lien is $104,151.88 and is not a final lien amount. I have enclosed documentation supporting the current lien amount as well as our subrogation, coordination of benefits, and assignment language. We are processing more payments as this letter is being sent.

(J.A. at 857.) In a subsequent telephone conversation on March 14, 1995, between Wilkes and Defendant's Claims Supervisor, Kay Nichols, Wilkes requested that Defendant pay "seventy-five cents on the dollar" to settle Plaintiff's subrogation claim. Nichols explained Michigan's no-fault insurance coverage to Wilkes, and advised that if Defendant was primarily liable, Defendant would reimburse Plaintiff one-hundred percent.

Wilkes sent a letter dated March 29, 1995, to Nichols, and enclosed a copy of Plaintiff's entire policy therewith, citing several portions of that policy to support Plaintiff's claim, and requested prompt reimbursement from Defendant to avoid litigation. Subsequently, Defendant's claims staff reviewed Plaintiff's policy to ascertain whether Plaintiff was primarily liable for Andrea's medical expenses.

By way of letter dated May 11, 1995, Defendant forwarded Plaintiff's ERISA plan and Wilkes' March 29, 1995, letter to Attorney Elaine I. Harding of Defendant's

legal staff, and requested her opinion as to whether Plaintiff was primarily liable. Harding and another attorney in Defendant's legal department, Chris Hoehn, reviewed Plaintiff's ERISA plan and concluded that Plaintiff was primarily liable for Andrea's medical expenses. On or about June 28, 1995, Wilkes professed to Harding that Defendant owed fifty percent of the medical benefits that Plaintiff was paying, and that Wilkes would send Harding case law in support of his position.

On or about June 29, 1995, Defendant's policy which covered Andrea as well as a copy of Michigan's statutory "one-year back" provision were faxed to Wilkes; Wilkes then informed Harding that he was researching the issue, but that he thought Defendant owed fifty percent or nothing at all. On or about July 6, 1995, Wilkes sent Harding a facsimile containing the following:

(a) A fax cover sheet written by Mr. Wilkes, which referred to the enclosed "authority we have to proceed with a 'dec action' to resolve this matter," and which offered "one last chance to settle this" claim; and

(b) A 5-page letter, which explained AMS's position that AAA was primarily liable, or at least 50% liable.

(J.A. at 851, 860-65.)

Thereafter, various facsimile and verbal communications were exchanged between Wilkes and Harding from August

of 1995, to September of 1995. In September of 1995, Harding drafted a letter on behalf of Defendant to Wilkes, which memorialized Defendant's previous denials of Plaintiff's reimbursement claim. On or about October 16, 1995, Wilkes responded and informed Harding that Plaintiff would settle for $15,000 or "whatever;" Harding rejected Wilkes' offer. Thereafter, Harding had no further contact with Wilkes concerning Plaintiff's reimbursement for Andrea's medical expenses, nor received any other communications regarding the matter, until Plaintiff's attorneys became involved.

In September of 1995, Defendant decided to pay Tull's insurance premium for Tull's COBRA conversion policy to extend Andrea's health insurance coverage with Plaintiff from August 1, 1995, to July 31, 1996. Defendant claims that it did so in order to maintain Plaintiff's status as primary payor of Andrea's medical expenses. On October 31, 1995, Defendant issued a check to Plaintiff in the amount of $4,218.56 as payment for the first year's premium on Tull's conversion policy. On August 19, 1996, Defendant issued a check to Plaintiff as payment for the second year's premium for Tull's COBRA conversion policy. However, Plaintiff returned Defendant's $6,331.08 payment, and terminated Tull's health insurance coverage effective August 1, 1996.

On about March 18, 1997, Defendant was advised that the matter was now being handled by Plaintiff's legal counsel. After an exchange of letters and other documents such as insurance plans and case law, Defendant once again advised Plaintiff's attorneys that it was denying Plaintiff's reimbursement claim during a March 6, 1998, telephone conversation.

Subsequently, on April 27, 1998, Plaintiff filed a lawsuit against Defendant regarding its claim for payments made on behalf of Andrea. On July 16, 1998, the district court entered an order consolidating this case with the case that Plaintiff filed against Defendant for reimbursement of payments made on behalf of Coan and Williamson. On January 20, 1999, Plaintiff filed a motion for summary judgment; Defendant replied in the form of a cross-motion for summary judgment; and on September 9, 1999, the district court issued a Memorandum and Order wherein the court granted Defendant's motion, while denying Plaintiff's motion for the same. In doing so, the court did not address Defendant's argument that Plaintiff's suit with respect to Andrea was barred under the "one-year back" rule; instead, the court found that Defendant was secondarily liable for payment of Andrea's medical bills under Mich. Comp. Laws Ann. 500.3109a, thereby rejecting Plaintiff's claim that § 500.3109 was preempted by § 1144(a) of ERISA. Specifically, the district court opined as follows:

> Although § 3109a of Michigan's No Fault Act "relates to" ERISA plans, it "regulates insurance" and thus is saved from ERISA preemption by the savings clause. *See Northern Group Servs., Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 89-90 (6th Cir. 1987). *See also FMC Corp. v. Holliday*, 498 U.S. 52, 58-61 (1990); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-46 (1985). The deemer clause does not apply here because, as AMS concedes, the plan is not self-funded. *See FMC*, 498 U.S. at 61; *UNUM Life Ins. Co. v. Ward*, __ U.S. __, 119 S. Ct. 1380, 1386 n.2

(1999) ("Self-insured ERISA plans . . . are generally sheltered from state insurance regulation.") Thus, because it is saved from ERISA preemption, § 3109a of Michigan's No-Fault Act applies in this case.

The Michigan Court of Appeals recently reached the same conclusion in *American Medical Security Inc. v. Allstate Ins. Co.*, __ Mich. App. __, 1999 WL 231661, at *2 (Apr. 20, 1999). There, AMS sued Allstate for reimbursement, and the material facts are indistinguishable from this case. The court of appeals stated:

> [T]he parties agree that plaintiff's group plan qualifies as an employee welfare benefit plan under ERISA. The plan however, is clearly not self-funded, but rather has purchased insurance through United Wisconsin. The issue is whether § 3109a is preempted in a situation where the ERISA plan is not self-funded but has purchased insurance coverage. We hold that it does not.

(J.A. at 1163-64; footnote omitted.) The district court also found that under *Federal Kemper Insurance Co. v. Health Insurance Administration, Inc.*, 383 N.W.2d 590 (Mich. 1986), Plaintiff's claim failed inasmuch as in *Federal Kemper* the Michigan Supreme Court held that when a health care plan and a no-fault insurer each seek to escape liability through competing coordination of benefits clauses, the health care plan is primarily liable and the no-fault insurer is secondarily liable.

Plaintiff filed a timely notice of appeal regarding the district court's decisions in both cases. The appeals were consolidated by order of this Court on October 8, 1999.

DISCUSSION

This Court reviews a district court's order granting summary judgment *de novo*. *Equitable Life Assur. Soc'y v. Poe*, 143 F.3d 1013, 1015 (6th Cir. 1998). Summary judgment is appropriate where "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c).

A. Case No. 98-1973 — Violation of Michigan's "One Year-Back" Rule

Plaintiff argues that the district court erred in applying Michigan's "one-year back" rule, Mich. Comp. Laws Ann. § 500.3145, on the basis that Plaintiff's claim should not be analyzed as one for subrogation under Michigan's No Fault Act, but on the basis of an action brought under ERISA, 29 U.S.C. § 1132(a)(1)(B), to recover benefits. Plaintiff contends that as a § 1132(a)(1)(B) claim, the applicable statute of limitations is six years pursuant to Mich. Comp. Laws Ann. § 600.5807(8) for breach of contract disputes, as well as pursuant to Mich. Comp. Laws Ann. § 600.5813 for general personal actions.[1]

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1. Section § 5807(8) provides that the "period of limitations is 6 years for all . . . actions to recover damages or sums due for breach

(Cont'd)

Appendix A

Defendant argues that the district court properly characterized Plaintiff as a subrogee to the interests of Coan and Williamson. However, Defendant also contends that whether the causes of action pleaded in Plaintiff's suits are characterized as suits to obtain benefits as subrogees, or as actions brought by Plaintiff to recover benefits under 29 U.S.C. § 1132(a)(1)(B), the district court properly granted summary judgment to Defendant due to the expiration of the period of limitation on recovery of benefits set forth in § 3145 of the Michigan No Fault Act.[2]

It is undisputed that the suits filed by Plaintiff seeking to recover payments made on behalf of Coan and Williamson

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(Cont'd)
of contract." MICH. COMP. LAWS ANN. § 600.5807(8) (West 2000). Michigan's general six-year statute of limitation period for personal actions as set forth in § 5183 provides as follows: "All other personal actions shall be commenced within the period of 6 years after the claims accrue and not afterwards unless a different period is stated in the statutes." MICH. COMP. LAWS ANN. § 600.5813 (West 2000).

2. Michigan's one-year statute of limitations provision as set forth in § 3145 provides as follows:

> An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.

MICH. COMP. LAWS ANN. § 500.3145 (West 2000).

were filed more than one year after the last payment made by Plaintiff for medical expenses incurred by the respective parties, and that Plaintiff's claims would therefore be time barred if § 3145 applied. The dispute, in turn, centers around which statutory provision should be applied, § 3145 of Michigan's No Fault Act, or §§ 5813, 5807(8) of Michigan's general provisions for a personal action or breach of contract claim, in determining the appropriate limitations period. We hold that § 3145 applies, thus making the applicable statute of limitations one year.

In *Federal Kemper Insurance Co. v. Western Insurance Cos.*, 293 N.W.2d 765, 767 (Mich. Ct. App. 1980), the Michigan Court of Appeals opined that "where an insurer, whose liability is arguably secondary to that of a primary insurer, pays the claim, it becomes subrogated to the rights of the insured." The court reasoned that a suit for subrogation brought by the secondary insurer against the primary insurer is the preferable method of handling the dispute inasmuch as the insured person is provided the benefits to which he is entitled, while the insurers are left to settle the liabilities. *Id.* This policy is consistent with that behind Michigan's no-fault provisions.

Moreover, the *Federal Kemper* court noted that its holding was consistent with previous decisions from the court such as *Home Insurance Co. v. Rosquin*, 282 N.W.2d 446 (Mich. Ct. App. 1979), where the court held that because an insurance company which had paid property protection insurance benefits to its insured but did not sue the defendant for subrogation within the one-year statute of limitations set forth in § 3145, its action was barred. *See Federal Kemper*,

293 N.W.2d at 768. The court observed, as did the court in Rosquin, that although the result may have appeared harsh, § 3145 is clear and " 'plaintiff is an insurance company itself and is presumably well aware of the much-publicized insurance law of this state.' " *Id.* (quoting *Rosquin*, 282 N.W.2d at 448).

A more recent decision from the Michigan Court of Appeals provides additional guidance. In *Titan Insurance Company v. Farmers Insurance Exchange*, 615 N.W.2d 774, 775-76 (Mich. Ct. App. 2000), the court set forth the characterization of the type of case which falls under the one-year period for claims under § 3145 of Michigan's No Fault Act. Specifically, in *Titan*, the Michigan Court of Appeals stated that those cases "in which an insurer's right to recovery or reimbursement from another insurer [is] subrogated to the insured's right to recovery[, the case is] subject to the period of limitation in § 3145" of Michigan's No Fault Act. *See id.* at 776 (citing *Amerisure Cos. v. State Farm Mut. Auto. Ins. Co.*, 564 N.W.2d 65 (Mich. Ct. App. 1997); *Michigan Mut. Ins. Co. v. Home Mut. Ins. Co.*, 310 N.W.2d 362 (Mich. Ct. App. 1981); *Federal Kemper Ins. Co. v. Western Ins. Cos.*, 293 N.W.2d 765 (Mich. Ct. App. 1980); *Keller v. Losinski*, 285 N.W.2d 334 (Mich. Ct. App. 1979)).

Simply put, *Titan* reiterated and confirmed what the Michigan courts have consistently held: that § 3145 applies to reimbursement suits between no-fault insurers. And so it goes that in this case, where Plaintiff, as a health insurer, is seeking recovery of payments made on behalf of an insured who is also covered by Defendant, as a no-fault insurer,

Plaintiff is doing so under a subrogation theory and is therefore "subject to the period of limitation in § 3145."[3] *See Titan*, 615 N.W.2d at 776. This is not a harsh or unreasonable standard to which Plaintiff should be held inasmuch as Plaintiff "is an insurance company itself and is presumably well aware of the much-publicized insurance law of this state." *Federal Kemper*, 293 N.W.2d at 768 (internal quotation marks omitted).

We are not persuaded otherwise by Plaintiff's reliance upon two cases from the Eastern District of Michigan. Specifically, Plaintiff relies upon *Western Mutual Life Insurance Co. v. Wall*, 903 F. Supp. 1155 (E.D. Mich. 1995) and *N.A.L.C. Health Benefits Plan v. Lunsford*, 879 F. Supp. 760 (E.D. Mich. 1995); we find both of these cases distinguishable and therefore of no assistance to Plaintiff's case.

Plaintiff claims that *Wall* is "binding precedent" for "action[s] under ERISA for reimbursement for medical expenses for which a no-fault insurer was primarily liable." *See* Plaintiff's Brief on Appeal at 18. Even assuming *arguendo* that Plaintiff's statement is a correct proposition of law, as will be explained in the following section, *Wall* is inapposite to the case at hand inasmuch as the plan that Plaintiff administers is not self-funded as was the case in *Wall*; Michigan's No Fault Act is not preempted; and Defendant AAA is not the primary insurer. *See* discussion *infra* Part B.

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3. This conclusion is bolstered by the fact that Plaintiff sought reimbursement for Andrea claiming it was a "subrogee." *See* discussion *infra* Part B., Case No. 99-2110.

In a similar fashion, Plaintiff's reliance upon *N.A.L.C. Health Benefits Plan v. Lunsford*, 879 F. Supp. 760 (E.D. Mich. 1995), is misplaced. As noted by the district court, although *Lunsford* essentially allowed a medical insurer to avoid the "one-year back" rule in seeking reimbursement from a no-fault insurer, the court did so on the basis that the claim involved a plan that was preempted by the Federal Employees Health Benefit Act. The federal plan had a provision which "in general, requires all enrollees to reimburse it with any funds that are subsequently obtained from a third party as a result of a lawsuit, settlement, or otherwise." *Id.* at 762. Because the plaintiff would have been barred from bringing her claim against her no-fault insurer to reimburse her medical insurer if she were bound by § 3145, the district court found that § 3145 did not apply. *Id.* The court reasoned that "when drafting the Michigan 'No Fault Motor Vehicle Act,' including its statute of limitations, the state Legislature neither anticipated nor considered the fact that, due to the federal scheme of reimbursement, federal employees would have no standing to seek or sue their no-fault carriers for benefits until they had recovered and reimbursed federal plans with their third-party proceeds." *Id.* at 766. Because the matter at hand does not involve a federal scheme of reimbursement, Plaintiff erroneously relies upon the limited holding of *Lundsford.*

In an alternative argument, Defendant claims that even if this Court were to ignore the district court's reasoning and characterize this case not as one for subrogation, but as one for reimbursement of ERISA-paid benefits which is contractual in nature, the "one-year back" rule would apply nonetheless because it is the more specific of two possible

statutory provisions. *See* Defendant's Brief on Appeal at 31-33 (citing *Adamson v. Armco, Inc.*, 44 F.3d 650, 652 (8th Cir. 1995)). Because we agree that Plaintiff's claim is one for subrogation, we need not address Defendant's alternative argument.

Accordingly, because Plaintiff seeks reimbursement from Defendant as subrogee to Coan and Williamson, Plaintiff's claims are subject to the one-year statute of limitations set forth in § 3145. Therefore the district court did not err in granting Defendant's motion for summary judgment on this basis; however, as will be explained below, the plans which Plaintiff administers are not self-funded or preempted by ERISA such that Defendant is the secondary insurer in this matter in any event.

B. Case No. 99-2110 — Violation of Michigan's "*Federal Kemper*" Rule?

In *Federal Kemper Insurance Co., Inc. v. Health Insurance Administration, Inc.*, the Michigan Supreme Court opined that § 3109a "mandates that no-fault carriers offer coordination of benefits at reduced premiums when the insured has 'other health and accident coverage.' "[4]

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4. Section 3109a provides in relevant part as follows:

> An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured . . . .

MICH. COMP. LAWS ANN. § 500.3109a. (West 1993).

383 N.W.2d 590, 594 (Mich. 1986), *overruled in part by Auto Club Ins. Ass'n v. Frederick & Herrud, Inc.*, 505 N.W.2d 820 (Mich. 1993). As a result of this statutory requirement, *Federal Kemper* developed a priority of coverage rule such that when there is a priority dispute between a no-fault insurer which has issued a coordinated policy under § 3109a and an accident victim's other health coverage provider, both of which contain a coordination of benefits provision, the health insurer will be deemed primary. *See id.* at 596. This rule has come to be known as the *Federal Kemper* rule.

When, as in the case at hand, the no-fault coordination of benefits provision conflicts with a coordination of benefits provision governed by ERISA, the Court must first consider whether the Michigan's no-fault law is preempted under ERISA before applying the *Federal Kemper* rule.

1. Preemption under ERISA

ERISA's preemption clause provides in relevant part that "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144(a). ERISA's "savings clause" qualifies the preemption clause when it states that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). However, ERISA's "deemer clause," which provides as follows, may override the savings clause for purposes of preemption under ERISA's.

Appendix A

> Neither an employee benefit plan . . . nor any trust established under such plan, shall be deemed to be an insurance company or other insurer, bank, trust company or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B).

2. Whether § 3109(a) is Preempted in the Matter at Hand

Plaintiff claims that the determination of whether § 3109a is preempted is not based upon whether the plan at issue is self-funded, but on the state law itself. Plaintiff contends that the *Federal Kemper* rule does not fall within ERISA's savings clause, and argues that the district court assumed that the *Federal Kemper* rule constituted a law regulating insurance and thus was saved from preemption without making the proper inquiry. Plaintiff concludes that upon making the proper inquiry, the *Federal Kemper* rule cannot be considered "saved" from ERISA preemption. We disagree.

In the case at hand, there is no dispute that § 3109 "relates" to the employee benefit plans administered by Plaintiff for purposes of ERISA's preemption clause. *See* 29 U.S.C. § 1144(a). Therefore the next step in the analysis is to determine whether § 3109a "regulates"

insurance for purposes of satisfying ERISA's savings clause. *See* 29 U.S.C. § 1144(b)(2)(A). This determination is made by first asking whether, from a common sense view of the matter, the provision at issue regulates insurance. *See Unum Life Ins. Co. v. Ward*, 526 U.S. 358, 367 (1999). If so, we are to consider three factors to determine whether § 3109a can be considered within the "business of insurance" as the term is used in the McCarran Ferguson Act, 15 U.S.C. § 1011 *et seq. See id.* This three-factor inquiry involves, 1) whether the practice has the effect of transferring or spreading a policy holder's risk; 2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and 3) whether the practice is limited to entities within the insurance industry. *See id.* However, the Supreme Court has qualified this three-factor inquiry, finding that a state regulation need not satisfy all three McCarran Ferguson factors in order to regulate insurance under ERISA's savings clause. *See id.* at 373.

As applied to § 3109a, this Court has already spoken as to whether this provision regulates insurance for purposes of the savings clause. Specifically, in *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, this Court had occasion to determine whether § 3109a was preempted under ERISA under the jurisprudential principles noted above, and found as follows:

> [T]he Michigan coordination of benefits law controls the terms of the insurance contracts. The Michigan law clearly "regulates insurance" within the meaning of the savings clause. This conclusion comports both with a common sense view of the

> statutory language and with a more formal assessment that the practice falls within the meaning of "business of insurance" covered by the McCarran Ferguson Act.

833 F.2d 85, 89-90 (6th Cir. 1987). The Court went on to determine that the deemer clause did not override the savings clause as applied to § 3109a, even when the plan at issue was self-funded. *See id.* at 95.

Shortly after *Northern Group* was decided, the United States Supreme Court effectively overruled *Northern Group*, but only as applied to self- funded plans. *See FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). Specifically, in *FMC Corp.*, the Supreme Court held that ERISA preempts all state regulation of self-funded ERISA employee welfare benefit plans; at the same time, however, the Court distinguished those plans that are insured, and found that the state may regulate insured plans indirectly by regulating the insurer and its contracts. *See id.* at 63-64 (noting that "the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans"). The Court focused on the deemer clause in making this determination, and opined as follows:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the saving clause. . . . On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer

> for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Id. at 61 (alteration in original).

Following the Supreme Court's lead, this Court observed that *self-funded* ERISA plans are to be distinguished from insured plans when applying ERISA's deemer clause, and therefore concluded that ERISA's deemer clause would exempt the uninsured ERISA plan from Michigan's § 3109a. *See Lincoln Mut. Cas. Co. v. Lectron Prods., Inc.*, 970 F.2d 206, 209 (6th Cir. 1992). Specifically, this Court held that:

> Upon review of the facts in the instant case, we conclude that Mich. Comp. Laws § 500.3109a, as it relates to the [instant self-funded] Plan, is not "saved" under the insurance regulation exception to preemption because, under the "deemer" clause, the Plan is " 'deemed' not to be an insurance company for purposes of state laws," such as § 3109a, that purport to regulate insurance contracts.

Id. at 210. Simply put, *Lincoln Mutual* held that because the ERISA plan was self-funded, Michigan's no-fault laws were preempted. *See id.*; *see also Auto Club Ins. Assoc. v. Health and Welfare Plans*, 961 F.2d 588, 593 (6th Cir. 1992)

(holding that "self-insured ERISA plans, including self-insured ERISA plans containing coordination of benefits clauses, are not reached by 500.3109a"); *Auto Club Ins. Ass'n v. Frederick & Herrud, Inc.*, 505 N.W.2d 820, 834 (Mich. 1993) (overruling *Federal Kemper* only to the extent that the *Federal Kemper* rule did not apply to self-funded plans, while couching its decision as a "narrow holding"); *Am. Med. Sec., Inc. v. Allstate Ins. Co.*, 597 N.W.2d 244, 247 (Mich. Ct. App. 1999) (finding that because the plan at issue was not self-funded, § 3109a applied). *Cf. Auto Owners Ins. Co. v. Thorn Apple Valley*, 31 F.3d 371, 374 (6th Cir. 1994) (stating that "when a traditional insurance policy and a qualified ERISA plan contain conflicting coordination of benefits clauses, the terms of the ERISA plan including its COB clause, must be given full effect").

Although this Court has not squarely addressed the primacy of coverage issue between a coordinated no-fault policy and an insurance policy purchased by an ERISA plan, we believe that the jurisprudence relating to this issue clearly indicates that § 3109a is not preempted under such circumstances. This Court has already found that § 3109a "regulates" insurance for purposes of the savings clause, *see Northern Group*, 833 F.2d at 89-90; *Northern Group* has not been overruled as to this finding; and, because the plan at issue is not self-funded, the deemer clause does not override the savings clause, thereby subjecting the plan to state regulation. *See FMC Corp.*, 498 U.S. at 61.

This same conclusion has been similarly reached in the Michigan federal district courts that have considered the issue. *See Citizens Ins. Co. of Am. v. Am. Med. Sec., Inc.*,

92 F. Supp. 2d 663, 668-71 (W.D. Mich. 2000) (finding that "[b]ecause the deemer clause prevents a state from deeming an ERISA plan to be an insurance company, self-insured ERISA plans are generally sheltered from state insurance regulation," but because the plan at issue was not self-funded, it was subject to § 3109a); *Progressive Mich. Ins. Co. v. United Wisc. Life Ins. Co.*, 84 F. Supp. 2d 848, 853 (E.D. Mich. 2000) ("In sum, § 3109 of Michigan's no-fault law is 'saved' under ERISA's saving clause. Accordingly, Michigan law, not federal law, governs this priority dispute. . . . Moreover, because the ERISA plan at issue here is funded by an insurance policy as opposed to being self-funded, ERISA's deemer clause will not exempt the plan from § 3019a of Michigan's no-fault law."); *Am. Med. Sec., Inc. v. State Farm Auto. Ins.*, 82 F. Supp. 2d 717, 719 (E.D. Mich. 2000) (finding that ERISA did not preempt § 3109a, and that the plaintiff medical insurer, which again was AMS, was therefore primarily liable for the insured's medical expenses while the insured's no-fault provider was secondarily liable).

3. Application of § 3109a or Michigan's *Federal Kemper* Rule

Because Michigan's no-fault law is not preempted under the facts of this case, the district court properly concluded that Plaintiff is the primary insurer. Under Michigan law, where no-fault coverage and health care coverage are coordinated, as in the case at hand, the health insurer is primarily liable for the insured's medical expenses. *See* MICH. COMP. LAWS ANN. § 500.3109a; *Federal Kemper*, 383 N.W.2d at 596. Therefore, the insured ERISA plan at issue is

primarily responsible for Andrea's medical expenses, and likewise in the case of Coan and Williamson, resulting from the separate automobile accidents in which these insured individuals were involved.

CONCLUSION

For the above stated reasons, we hold that the district court properly granted summary judgment to Defendant, and properly denied summary judgment to Plaintiff, in **Case No. 98-1973** as well as in **Case No. 99-2110,** and we therefore **AFFIRM** the district court's orders in both cases.

Appendix A

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Nos. 98-1973; 99-2110

AMERICAN MEDICAL SECURITY, INC.,

Plaintiff – Appellant,

v.

AUTO CLUB INSURANCE ASSOCIATION
OF MICHIGAN,

Defendant – Appellee.

Before: DAUGHTREY and CLAY, Circuit Judges;
RUSSELL, District Judge.

JUDGMENT

On Appeal from the United States District Court
for the Eastern District of Michigan at Detroit.

THIS CAUSE was heard on the record from the district court and was argued by counsel.

IN CONSIDERATION WHEREOF, it is ORDERED that the orders of the district court granting summary judgment to defendant Auto Club Insurance Association of Michigan, and denying summary judgment to plaintiff American Medical Security, Inc., in both cases are AFFIRMED.

**ENTERED BY ORDER OF
THE COURT**

s/ Leonard Green
Leonard Green, Clerk

APPENDIX B — MEMORANDUM AND ORDER AND JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION DATED AND FILED SEPTEMBER 9, 1999

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

CASE No. 97-75632
HONORABLE AVERN COHN

AMERICAN MEDICAL SECURITY, INC.,
a Delaware corporation,

Plaintiff,

v.

AAA MICHIGAN, a Michigan corporation,

Defendant.

MEMORANDUM AND ORDER

I.

This is an insurance coverage dispute. Plaintiff American Medical Security, Inc. (AMS) is the third-party administrator of a group employee medical plan that provided medical care coverage to Andrea Teagan (Teagan). When Teagan was injured in a car accident, AMS paid her medical expenses. According to AMS, however, its insurance coverage was in

excess of AAA's no-fault policy coverage, which also covers medical expenses arising from the accident. AMS is suing AAA for the amounts it paid, claiming AAA is primarily liable.

Before the Court are two motions. AMS moves for summary judgment, arguing that its claim for reimbursement is not barred by the "one-year back" rule of the Michigan No-Fault Act, Mich. Comp. Laws Ann. § 500.3145, because the six-year limitation period for contract actions is applicable. AMS also contends that the Employment Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, preempts state insurance law. AAA responds with its own motion for summary judgment, arguing that AMS's claim is barred by the "one-year back" rule, and that the because the plan is not self-funded, ERISA does not preempt state law under the circumstances. According to AAA, AMS is primarily liable for Teagan's medical expenses under state law.

For the following reasons, ERISA does not preempt Michigan law. Under Michigan law, AAA is secondarily liable. Accordingly, AMS's motion will be denied, and AAA's motion will be granted.

II.

A.

AMS is subrogated to the rights of Teagan. This action for reimbursement of benefits paid to Teagan is a companion to, and was consolidated with, AMS's action to recover

benefits paid on behalf of Peter Coan and Jerry Williamson, which was dismissed in the Memorandum and Order dated August 4, 1998. In footnote 3 of the Memorandum and Order, the Court noted that the parties did not make arguments with respect to the Teagan matter. Thus Teagan's case was not dismissed.

B.

Teagan was injured in a car accident in Michigan on July 8, 1994. Teagan's mother, Lillian Tull (Tull), worked for Tempo West, Inc. and was a participant in its employee benefit plan (plan). The plan covered Teagan. AMS administered the plan and medical coverage was provided by the United Wisconsin Life Insurance Company (United Wisconsin). Teagan was also covered under Tull's no-fault insurance policy, which was issued by AAA (no-fault policy). The plan[1] and the no-fault policy[2] each contain coordination of benefits clauses that ostensibly conflict. AMS paid

---

1. The plan contained the following provision on excess coverage:

> **Excess Coverage**
>
> No benefits are payable for Injury or Sickness for which there is other insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent. If We make payment on Your behalf, You agree to assign to Us any right You have against the other insurer.

2. The no-fault policy is not part of the record.

$205,317.89 for Teagan's medical expenses and brings this action to obtain reimbursement from AAA on the ground that AAA is primarily liable for Teagan's medical expenses.

III.

A. Summary Judgment

Summary judgment will be granted when the moving party demonstrates that there is "no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). There is no genuine issue of material fact when "the record taken as a whole could not lead a rational trier of fact to find for the non-moving party." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986).

The Court must decide "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *In re Dollar Corp.*, 25 F.3d 1320, 1323 (6th Cir. 1994) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52 (1986)). In so doing, the Court "must view the evidence in the light most favorable to the non-moving party." *Employers Ins. of Wausau v. Petroleum Specialties, Inc.*, 69 F.3d 98, 101 (6th Cir. 1995).

B. ERISA Preemption

1.

AAA argues that AMS is primarily liable for Teagan's injuries because ERISA does not preempt Mich. Comp. Laws

Appendix B

Ann. § 500.3109a, which governs the coordination of benefits under the No-Fault Act.[3]

ERISA contains a broad preemption clause,[4] a broad savings clause,[5] and a narrow deemer clause.[6] These provisions have been reconciled as follows:

---

3. Under Mich. Comp. Laws Ann. § 500.3109a:

> An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

4. The preemption clause, 29 U.S.C. § 1144(a), provides: "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."

5. The savings clause, 29 U.S.C. § 1144(b)(2)(A), provides: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

6. The deemer clause, 29 U.S.C. § 1144(b)(2)(B), provides: "Neither an employee benefit plan . . . nor any trust established under such plan, shall be deemed to be an insurance company or other

(Cont'd)

Appendix B

> [I]t appears that if a state law "relate[s] to" an ERISA benefit plan it is preempted; but if the state law "regulates insurance" it is not preempted. But an ERISA covered employee benefit plan that provides insurance coverage is "deemed" not to be an insurance company for purposes of state laws regulating insurance, and ERISA, therefore, preempts such state laws.

Lincoln Mut. Cas. Co. v. Lectron Products Inc., Employee Health Ben. Plan, 970 F.2d 206, 209-10 (6th Cir. 1992) (quoting *Liberty Mutual Ins. Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384, 1386 (6th Cir. 1989)).

Although § 3109a of Michigan's No-Fault Act "relates to" ERISA plans, it "regulates insurance" and thus is saved from ERISA preemption by the savings clause. *See Northern Group Servs., Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 89-90 (6th Cir. 1987).[7] *See also FMC Corp. v. Holliday*,

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(Cont'd)
insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

7. In *Auto Club Ins. Assoc. v. Health and Welfare Plans, Inc.*, 961 F.2d 588, 593 (6th Cir. 1992), the Sixth Circuit stated that the United States Supreme Court's decision in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), effectively overruled *Northern Group Services* "*insofar as self-insured ERISA plans are concerned.*" (Emphasis added). Thus, the conclusion that § 3109a "relates to" ERISA plans and "regulates insurance" in plans that are not self-funded was not overruled.

498 U.S. 52, 58-61 (1990); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-46 (1985). The deemer clause does not apply here because, as AMS concedes, the plan is not self-funded. *See FMC*, 498 U.S. at 61; *UNUM Life Ins. Co. v. Ward*, __ U.S. __, __, 119 S. Ct. 1380, 1386 n.2 (1999) ("Self-insured ERISA plans . . . are generally sheltered from state insurance regulation."). Thus, because it is saved from ERISA preemption, § 3109a of Michigan's No-Fault Act applies in this case.

The Michigan Court of Appeals recently reached the same conclusion in *American Medical Security Inc. v. Allstate Ins. Co.*, __ Mich. App. __, 1999 WL 231661 (Apr. 20, 1999). There, AMS sued Allstate for reimbursement, and the material facts are indistinguishable from this case. The court of appeals stated:

> [T]he parties agree that plaintiffs group plan qualifies as an employee welfare benefit plan under ERISA. The plan, however, is clearly not self-funded, but rather has purchased insurance through United Wisconsin. The issue is whether § 3109a is preempted in a situation where the ERISA plan is not self-funded but has purchased insurance coverage. We hold that it does not.

Id. at *2.

AMS's argument that the Sixth Circuit's decision in *Lincoln Mutual* alters this conclusion is wrong. In *Lincoln Mutual*, the Sixth Circuit held that ERISA applied to a self-insured plan that purchased stop-loss insurance to cover

its losses for catastrophic claims. Under the deemer clause, the self-insured plan was "deemed not to be an insurance company for purposes of state laws such as § 3109a" and thus not subject to state insurance law regulation. 970 F.2d at 210 (internal quotation marks omitted). The Sixth Circuit distinguished a self-insured plan from a plan that purchased insurance, noting that the state may "regulate the companies that insure ERISA plans." *Id.* "Although a plan may be affected by the state's regulations 'insofar as [the regulations] apply to the plan's insurer,' the effect is 'indirect' and, therefore, is not prohibited by federal law." *Id.* (citation omitted). In contrast to *Lincoln Mutual*, the plan in this case is not self-funded.

2.

AAA contends that because Michigan law applies, its liability is secondary to that of AMS. AMS, which focused on preemption in its papers, has not responded to this argument.

Two decisions of the Michigan Supreme Court are instructive on § 3109a and the coordination of benefits when the no-fault insurer and the plan each contend that the other is primarily liable for the expenses of the insured. The first decision, *Federal Kemper Ins. Co. v. Health Ins. Admin. Inc.*, 424 Mich. 537 (1986), clearly supports AAA's proposition that its liability is secondary to that of AMS. The supreme court noted that § 3109a "mandates that no-fault carriers offer coordination of benefits at reduced premiums when the insured has 'other health and accident coverage.' " The supreme court held that when a health care plan and a no-fault

insurer each seek to escape liability through competing coordination of benefits clauses, the health care plan is primarily liable and the no-fault insurer is secondarily liable. *See id.* at 551-52.

The supreme court overruled *Federal Kemper* to the extent it is inconsistent with the holding in *Auto Club Ins. Assoc. v. Frederick & Herrud, Inc.*, 443 Mich. 358 (1993). The narrow holding in *Frederick & Herrud*, however, is inapplicable here because ERISA does not apply. The insurance policies considered by the Michigan Supreme Court in *Frederick & Herrud* were self-funded. Therefore, the plan was deemed not to be an insurance company and was thus covered by ERISA. As the Michigan Supreme Court noted in *Frederick & Herrud*:

> We emphasize . . . that the primacy of health care coverage over that in a no-fault policy continues in Michigan jurisprudence in all cases not within the purview of this narrow holding.

Id. at 390.

In contrast to *Frederick & Herrud*, ERISA does not apply here. Therefore, AAA is secondarily liable under *Federal Kemper*. AAA is entitled to summary judgment.

IV.

For the foregoing reasons, AMS's motion is DENIED, and AAA's motion is GRANTED. This case is DISMISSED.

Appendix B

SO ORDERED.

s/ Avern Cohn
AVERN COHN
UNITED STATES DISTRICT
JUDGE

DATED: SEP 09 1999
Detroit, Michigan

Appendix B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

CASE NUMBER 97-75632

AMERICAN MEDICAL SECURITY, INC.,

Plaintiff,

v.

AAA MICHIGAN,

Defendant.

JUDGMENT IN A CIVIL CASE

* * *

☒ **Decision by Court.** This action came to hearing before the Court. The issues have been heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED plaintiff's motion for summary judgment is DENIED, defendant's motion for summary judgment is GRANTED and the above case is DISMISSED.

September 9, 1999
Date

DAVID WEAVER
Clerk

s/ Judy Cassady
(By) Deputy Clerk
JUDY CASSADY

APPENDIX C — MEMORANDUM AND ORDER AND JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION DATED AND FILED AUGUST 4, 1998

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

CASE No. 97-75632
HONORABLE AVERN COHN

AMERICAN MEDICAL SECURITY, INC.,

Plaintiff,

v.

AAA MICHIGAN,*

Defendant.

MEMORANDUM AND ORDER

I.

This is an insurance coverage dispute. Plaintiff American Medical Security, Inc. (AMS) is the third-party administrator of group employee benefit plans that provided medical care coverage to Peter C. Coan (Coan) and Jerry Williamson

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* The actual name of defendant is Auto Club Insurance Association.

(Williamson).[1] Coan and Williamson also had no-fault automobile insurance through defendant AAA Michigan (AAA). When Coan was injured in a car accident, AMS paid out $197,857.85 for his medical expenses, and again when Williamson was injured in a car accident, AMS paid out $8239.38. According to AMS, however, its insurance coverage was in excess of AAA's no-fault policy coverage, which also covers medical expenses arising from the car accidents. AMS sued AAA for the amounts it paid, arguing that AAA is primarily liable.

Now before the Court are cross motions for summary judgment. AMS argues that the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, preempts state law and establishes that when an ERISA plan and a no-fault policy both purport to provide secondary coverage, the "other insurance" provision in the ERISA plan is to be given full effect. AAA chiefly counters that the one-year statute of limitations for subrogation actions under the Michigan No-Fault Act has run on AMS's claims.[2] AMS characterizes the case as a dispute between benefit providers over whose coverage is primary; it says that this makes the case a contract dispute. Therefore AMS argues that the six-year statute of limitations for contract actions applies to its claims.

---

1. Coan worked for Daniels Glass Co. and was a participant in its employee benefit plan, while Williamson worked for C. & M. Masonry and was a participant in its employee benefit plan.

2. AAA also argues that AMS's ERISA preemption argument only applies to self-funded plans and not to those at issue in this case, i.e., plans funded through the purchase of insurance. Court does not need to reach this issue.

For the following reasons, AMS's motion for summary judgment is DENIED, and AAA's motion for summary judgment is GRANTED. The case is DISMISSED.[3]

II.

The employee benefit plans administered by AMS contained the following provision on excess coverage:

> **Excess Coverage**
>
> No benefits are payable for Injury or Sickness for which there is other insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent. If We make payment on Your behalf, You agree to assign to Us any right You have against the other insurer.

After compensating Coan and Williamson for their injuries, AMS requested reimbursement from AAA, writing that the "American Medical certificate of insurance provides that no benefits are payable for which there is other insurance providing medical payments or medical expense coverage, and it also provides for the right of subrogation."

---

3. In a companion case, AMS seeks reimbursement of benefits for Andrea Teagan (Teagan) under seemingly identical circumstances. *See American Medical Security, Inc. v. AAA Michigan*, No. 98-71754. Because the parties have not addressed the statute of limitations argument with respect to Teagan's case, the Court does not know if AMS's claims in that case are similarly barred.

AAA's no-fault automobile insurance indeed provides coverage for medical expenses arising from automobile accidents. AAA refused to reimburse AMS, however. AAA told AMS that it could not reimburse AMS for Coan's or Williamson's medical expenses because the requests were not made within one year of service. AMS does not dispute that it sought reimbursement more than one year after covering the medical expenses arising from the car accidents.

III.

Under the Michigan No-Fault Act, "the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced." M.S.A. § 24.13145(1). This is popularly called the "one-year back" rule. With regard to the benefits paid to Coan and Williamson, AMS did not seek reimbursement from AAA until after one year had passed. Based upon Michigan law, AMS has lost its right to maintain subrogation actions against AAA.

AMS argues that the six-year statute of limitations for a contract dispute applies to this action. *See* M.S.A. § 27A.5807(8).[4] "The gravamen of an action is determined

4. AMS also seems to suggest that federal common law dictates application of the six-year statute of limitations. This argument is not supported by 29 U.S.C. § 1132, which allows an insurer to enforce ERISA rights without setting a time limitation. "Generally, when a federal statute does not provide a statute of limitations, a court must borrow the most analogous state limitations period." *Snyder v. Boston Whaler, Inc.*, 892 F. Supp. 955, 960 (W.D. Mich. 1994). The question therefore concerns which limitations period to borrow.

by reading the claim as a whole. Further, this Court will look beyond procedural labels to see exactly what a party's complaint is before deciding whether it should be barred." *Belleville v. Hanby*, 152 Mich. App. 548, 551 (1986). AAA counters that, as in reimbursement actions between no-fault insurers, an action by a health insurer for reimbursement from a no-fault insurer should be characterized as subrogation. *See Amerisure Companies v. State Farm Mutual Automobile Ins. Co.*, 222 Mich. App. 97, 103 (1997) (finding that the one-year back rule "governs actions between no-fault insurers for recovery of monies mistakenly paid by the secondary insurer. Such actions are ones of subrogation, and, as such, plaintiff acquired no greater rights than [the insured] had against defendant.").

When AMS initially sought reimbursement from AAA for the medical expenses of Coan and Williamson, AMS admittedly invoked its rights of subrogation. The essence of AMS's claims sounds in subrogation; in addition, AMS and AAA do not have a contractual relationship. The cases AMS cites in support of its six-year statute of limitations argument are not to the contrary. In *Auto Club Ins. Ass'n v. New York Life Ins. Co.*, 440 Mich. 126 (1992), the Michigan Supreme Court applied the six-year statute of limitations to a reimbursement action by a secondary no-fault insurer against a primary medical insurer. *See id.* at 140. Yet the Michigan Supreme Court essentially found that the no-fault insurer was subrogated to the claims of the insured, *see id.* at 136, and that the medical insurer was not transformed into a no-fault insurer who could hide behind the relatively short one-year back rule. *See id.* at 139.

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The logical extension of *New York Life* is that (1) when AMS sued AAA for reimbursement, arguing that it was secondarily liable, it essentially asserted subrogation; (2) AMS is therefore subrogated to the claims of Coan and Williamson; and (3) AMS must therefore abide by the one-year back rule, which limits Coan and Williamson's rights to recovery. Because AMS sought reimbursement more than one year after the most recent allowable expenses, it cannot now bring these claims against AAA. As a party sophisticated in dealing with insurance disputes, AMS should have been aware of this time limitation and acted within the applicable period.[5]

---

5. Although the court in *NALC Health Benefits Plan v. Lunsford*, 879 F. Supp. 760 (E.D. Mich. 1995), essentially allowed a medical insurer to avoid the one-year back rule in seeking reimbursement from a no-fault insurer, *Lunsford* is factually distinguishable.

There plaintiff medical insurer, which was a federal health plan, sued its insured, Lunsford, for reimbursement. As the court noted, "[t]his health benefit plan . . . contains a provision which, in general, requires all enrollees to reimburse it with any funds that are subsequently obtained from a third party as a result of a lawsuit, settlement, or otherwise." *Id.* at 762.

Lunsford therefore sued her no-fault insurer to reimburse her medical insurer. Lunsford was hindered by the one-year back rule, however. The court allowed Lunsford to maintain an action against the no-fault insurer:

> Thus, it is clear to this Court that, when drafting the Michigan "No Fault Motor Vehicle Liability Act,"

(Cont'd)

Appendix C

SO ORDERED.

s/ Avern Cohn
AVERN COHN
UNITED STATES DISTRICT
JUDGE

DATED: AUG 04 1998
Detroit, Michigan

(Cont'd)

> including its statute of limitations, the state Legislature neither anticipated nor considered the fact that, due to the federal scheme of reimbursement, federal employees would have no standing to seek or sue their no-fault carriers for benefits until they had recovered and reimbursed the federal plans with their third-party proceeds.

Id. at 766.

The court was persuaded by the inequities of the rule as it applied to an insured contractually bound to seek reimbursement from her no-fault insurer. Because this case does not involve such inequities, and instead involves a sophisticated insurer fully able to act within the statute of limitations, the one-year back rule controls.

Appendix C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

CASE NUMBER 97-75632

AMERICAN MEDICAL SECURITY, INC.,

Plaintiff,

v.

AAA MICHIGAN,

Defendant.

JUDGMENT IN A CIVIL CASE

* * *

☒ **Decision by Court.** This action came to hearing before the Court. The issues have been heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED plaintiff's motion for summary judgment is DENIED; defendant's motion for summary judgment is GRANTED and the above case is DISMISSED.

August 4, 1998
Date

JOHN P. MAYER
Clerk

s/ Judy Cassady
(By) Deputy Clerk
JUDY CASSADY

Supreme Court, U.S.
FILED
MAY 8 2001
CLERK

(2)

No. 00-1535

In The

Supreme Court of the United States

AMERICAN MEDICAL SECURITY, INC.,

Petitioner,

v.

AAA MICHIGAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

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STATEMENT PURSUANT TO RULE 29.6

Petitioner has consistently styled Respondent as "AAA Michigan". The opinions of the United States Court of Appeals for the Sixth Circuit and the United States District Court for the Eastern District of Michigan refer to Respondent as "Auto Club Insurance Association of Michigan".

Although insurance premiums are paid to "AAA Michigan", the legal name of "AAA Michigan" is "Auto Club of Michigan". The "Auto Club of Michigan" is a wholly-owned subsidiary of the "Auto Club Group". The "Auto Club Group" is a non-profit Michigan corporation owned by its individual members.

The "Auto Club Insurance Association of Michigan" is a reciprocal inter-insurance exchange organized under Michigan law.

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SUPPLEMENT TO JURISDICTIONAL STATEMENT

Petitioner states unequivocally that the basis for the underlying lawsuits was "§ 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 891, as amended, 29 U.S.C. § 1132 (a)(1)(B)". Pet. at 1. Subsequently, Petitioner acknowledges that it "is a third-party administrator of insured employee welfare benefit plans governed by ERISA". Pet. at 3. By definition, Petitioner is neither a participant nor beneficiary of the Plans at issue. 29 U.S.C. § 1002 (7), (8).

STATUTORY PROVISIONS INVOLVED

Standing and subject-matter jurisdiction to bring a civil action under ERISA is conferred by 29 U.S.C. § 1132. Petitioner brought the two lawsuits involved here pursuant to 29 U.S.C. § 1132 (a)(1)(B):

"A civil action may be brought –

"(1) by a participant or beneficiary –"

* * *

"**(B)** to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;"

29 U.S.C. § 1132 (a)(3) provides that:

"A civil action may be brought –

"(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the

terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;"

29 U.S.C. § 1002 defines "participant", "beneficiary" and "fiduciary":

"(7) The term 'participant' means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

"(8) The term 'beneficiary' means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to benefits thereunder".

* * *

"(21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of

such plan. Such terms includes any person designated under section 1105(c)(1)(B) of this title."

SUPPLEMENT TO STATEMENT OF THE CASE

In Petitioner's Statement of the Case, Petitioner refers to the existence of "ERISA plans administered by AMS", but does not explain what comprises those plans. Pet. at 3. The ERISA plans covering Mr. Coan, Mr. Williamson, and Ms. Teagan (through her mother, Lillian Tull) consist wholly of insurance policies purchased by the employers of Mr. Coan, Mr. Williamson and Ms. Tull and issued by United Wisconsin Life Insurance Company ("UWL").

The policies provide that Petitioner, American Medical Security Inc, ("AMS") is the Trust Administrator. The Terms and Conditions include the following acknowledgment by the Employer that purchased the policy:

> "The Employer understands and agrees that the Trustee or the Trust Administrator are not the insurer. * * * The principal duty of the Trust Administrator is to administer and manage the insurance programs for the Trustee and for Employers who participate in the Trust. The insurance, **payment or denial of claims for benefits** under the policies and all other particulars are the **sole obligation of** and will be fulfilled by **the insurer** according to the terms of the insurance policies and according to the standard operating procedures of the insurer or its authorized representative."

(Emphasis added).

REASONS FOR DENYING THE WRIT

There exist three independent reasons for denying Petitioner's request for the issuance of a writ of certiorari. Consideration of the Question Presented is inappropriate in light of the record in this case. Both the Sixth Circuit and the District Court utilized the procedure outlined by this Court in *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358, 119 S. Ct. 1380, 143 L.Ed.2d 462 (1999), in determining that § 3109a of the Michigan No-Fault Act, M.C.L. 500.3109a; M.S.A. 24.13109(1), is applicable to the UWL policies at issue in this case by virtue of ERISA's "saving" clause, 29 U.S.C. § 1144(b)(2)(A). In any event, the question of whether § 3109a of the Michigan No-Fault Act is preempted by ERISA or saved from preemption by ERISA's "saving" clause does not present an issue of sufficient importance to warrant review by this Court.

I. Consideration of the Question Presented by the Petition for a Writ of Certiorari is Inappropriate in Light of the Record in this Case.

Consideration of the Question Presented by Petitioner is inappropriate when viewed in the context of the entire record in this matter. First, prior to any such consideration, this Court would have to make a determination as to subject-matter jurisdiction. Second, in order to reach the Question Presented, this Court would have to resolve the statute of limitations question in favor of Petitioner. Third, any decision by this Court as to the Question Presented will not be dispositive in this case due to the language of the UWL insurance policies themselves.

A. Prior to any Consideration of the Question Presented, this Court Would Have to Make a Determination as to Whether Subject-Matter Jurisdiction Exists Thereon.

Petitioner brought these actions pursuant to 29 U.S.C. § 1132 (a)(1)(B). Pet. at 1. 29 U.S.C. § 1132 (a)(1)(B) states that a civil action may be brought "by a participant or beneficiary * * * to recover benefit due to him under the terms of the plan, to enforce his rights under the terms of the plan, or clarify his rights to future benefits under the terms of the plan". Petitioner does not claim that it is a "participant" or "beneficiary" of the ERISA plans at issue. Indeed, Petitioner acknowledges that it "is a third-party administrator of insured employee welfare benefit plans governed by ERISA". Pet. at 3. On its face, a jurisdictional question is presented thereby.

Respondent acknowledges that no challenge to subject-matter jurisdiction was raised in either lower court. Respondent accepts full responsibility for that omission. Nonetheless, this Court has observed that it must first satisfy itself of subject-matter jurisdiction, even *sua sponte*, before reaching the merits of a dispute. *Freytag v. Commissioner of Internal Revenue*, 501 U.S. 868, 896, 111 S.Ct. 2631, 2648, 115 L.Ed.2d 764 (1991); *Insurance Corporation of Ireland, Ltd. v. Compagnie des Bauxites de Guinee*, 456 U.S. 694, 702, 102 S.Ct. 2099, 2104, 72 L.Ed.2d 492 (1982). See *Mt. Healthy City School District Board of Education v. Doyle*, 429 U.S. 274, 278, 97 S.Ct. 568, 571-572, 50 L.Ed.2d 471 (1977).

Both the Fourth and Sixth Circuits have held that a plan administrator cannot bring a cause of action pursuant to 29 U.S.C. § 1132 (a)(1)(B). *Alexander v. Electronic Data Systems Corp.*, 13 F.3d 940, 946 (6th Cir.1994); *Provident Life & Accident Insurance Company v. Waller*, 906 F.2d 985, 987-988 (4th Cir.), *cert. denied*, 498 U.S. 982, 111 S.Ct. 512, 112 L.Ed.2d 524 (1990). Adoption of the holdings in those cases would bar Petitioner's claims as presented on jurisdictional grounds.[1]

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[1] It is true that federal courts may excuse pleading defects if the facts alleged in the Complaint and the requested relief demonstrate the existence of a substantial federal question. *Schlesinger v. Councilman*, 420 U.S. 738, 742-743, 95 S.Ct. 1300, 1305-1306, 43 L.Ed.2d 591 (1975); *Wolfe v. Marsh*, 846 F.2d 782, 785, 269 U.S.App.D.C., 394, 397 (1988). Traveling down that hitherto-unbriefed road would, however, require that this Court confront further related jurisdictional questions before reaching the Question Presented. *Cf., O'Neal v. Kennamer*, 958 F.2d 1044, 1048 (11th Cir.1992). First, can Petitioner be considered a "fiduciary" for purposes of bringing these cases under the umbrella of 29 U.S.C. § 1132 (a)(3)? Because it is UWL, and not Petitioner, that has the sole responsibility and obligation for the payment or denial of claims, for the particular allegations of the Complaints at issue Petitioner should not be considered to be a "fiduciary" for bringing lawsuits pursuant to 29 U.S.C. § 1132 (a)(3)(B). *Michigan Affiliated Healthcare System, Inc. v. CC Systems Corporation of Michigan*, 139 F.3d 546, 548-549 (6th Cir.1998). Second, even if Petitioner were considered a "fiduciary", does the relief sought by these cases fall within the purview of 29 U.S.C. § 1132 (a)(3)? The Complaints in these cases seek "reimbursement from Defendant * * * for benefits which Plaintiff paid on behalf of Defendant's insured". Monetary damages are sought. On its face, such a claim does not appear to sound in equity. It is noteworthy that this Court recently evinced some interest in that question – albeit on a different set of facts. *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246, 1248 (9th Cir.),

B. In Order to Reach the Question Presented, this Court Would Have to Resolve the Statute of Limitations Question in Favor of Petitioner.

In each of the underlying cases, Respondent argued that Petitioner's Complaint was barred by application of the "one-year-back" rule set forth in M.C.L. § 500.3145(1); M.S.A. § 24.13145(1). As to Petitioner's lawsuit regarding payments made on behalf of Messrs. Coan and Williamson, both the District Court and the Sixth Circuit ruled in favor of Respondent. (Sixth Circuit Case No. 98-1973). The District Court and Sixth Circuit did not decide this question in Petitioner's lawsuit regarding payments made on behalf of Ms. Teagan. (Sixth Circuit Case No. 99-2110). To reach the Question Presented, at a minimum, this Court must reverse the Sixth Circuit's ruling as to Messrs. Coan and Williamson. (As to the lawsuit involving Ms. Teagan, its failure to be timely filed provided an alternative ground to affirm the District Court.)

1. Coan and Williamson – Sixth Circuit Case No. 98-1973

In ruling in favor of Respondent in the lawsuit seeking reimbursement of payments made on behalf of Messrs. Coan and Williamson, the District Court and Sixth Circuit followed guidelines established by this Court. In *International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW),*

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cert. granted, 121 S.Ct. 562, 148 L.Ed.2d 482, *cert. dismissed*, 121 S.Ct. 674, 148 L.Ed.2d 674 (2000).

AFL-CIO v. Hoosier Cardinal Corporation, 383 U.S. 696, 704-705, 86 S.Ct. 1107, 1113, 16 L.Ed.2d 192 (1966), this Court held that the timeliness of a federal lawsuit, where the statutory basis for such a lawsuit does not contain a period of limitation, "is to be determined, as a matter of federal law, by reference to the appropriate state statute of limitations".

Both the District Court, Pet. App. C, 42a-44a, and the Sixth Circuit, Pet. App. A, 14a-18a, determined which of the ostensibly competing statutes of limitations was most appropriate, agreeing with Respondent. Although Petitioner does not raise this argument to this Court, in the lower courts Petitioner argued that another Michigan statute of limitations was most appropriate. Resolution of this issue, therefore, depends solely on an analysis of Michigan state law, an insufficiently important enough basis on which to grant a petition for a writ of certiorari.

2. Teagan – Sixth Circuit Case No. 99-2110

Respondent emphasizes that the District Court and Sixth Circuit did not affirmatively rule in favor of Petitioner as to the timeliness of the lawsuit. Instead, those courts simply ignored the question. Thus, for this Court to reach a contrary conclusion as to the Question Presented, this Court must initially determine the statute of limitations question in favor of Petitioner.

Application of the analysis utilized by the District Court and Sixth Circuit in the lawsuit regarding Messrs. Coan and Williamson – unchallenged in the Petition – establishes that, had either court squarely considered this

question in the lawsuit regarding Ms. Teagan, it should have ruled in favor of Respondent and against Petitioner, thereby obviating any need to reach the Question Presented. Here again, resolution of this issue depends solely on an analysis of Michigan state law.

C. Any Decision by this Court as to the Question Presented Will not be Dispositive due to Language in the UWL Insurance Policies that Comprise the ERISA Plans at Issue, in Total.

Even were Petitioner to prevail on the Question Presented, so that the language of the UWL policies were controlling in these cases, application of the policy language would still render Petitioner primarily liable for the payment of the medical expenses at issue, leaving the parties in precisely the same position as at present. Two separate provisions of the UWL policies compel this result. In any event, to resolve this issue, it would be necessary for this Court to delve into the minutiae of a single insurance policy, clearly an insufficiently important basis on which to grant a petition for a writ of certiorari.

1. "Order of Benefit Determination" Language

As applied to Messrs. Coan and Williamson, the UWL Order of Benefit Determination provision specifies that where the UWL coordination provisions do not agree with the coordination provisions of the other plan at issue (here, valid Michigan no-fault automobile insurance policies), the UWL policy will waive its rules and coordinate benefits according to the other plan. In other words,

pursuant to the terms of the UWL policy, the no-fault coordination provisions would apply, making Petitioner primarily liable for the payment of the medical expenses at issue. *Federal Kemper Insurance Co., Inc. v. Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W.2d 590 (1986), *overruled as to self-funded ERISA plans by Auto Club Insurance Association v. Frederick & Herrud, Inc.*, 443 Mich. 358, 505 N.W.2d 820 (1993).

As applied to Ms. Teagan, the UWL Order of Benefit Determination specifies that the UWL policy is primary because Ms. Teagan's mother (Ms. Teagan was a dependent of her mother at the time of the accident) was covered by the UWL policy prior to being insured with Respondent.

In neither case, then, would the Judgment of the Sixth Circuit be altered. Pet. App. A, 27a.

Petitioner relies on other language in the UWL policy. Pet. at 3. However, the language relied upon by Petitioner (the Excess Coverage provision) is in irreconcilable conflict with the Order of Benefit Determination provision.[2] Pursuant to well-established rules of policy interpretation, the Order of Benefit Determination provision must

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[2] Read literally, as suggested by Petitioner below, the Excess Coverage provision obviates the need for any Coordination of Benefits provision because whenever "there is other insurance providing medical payments or medical expense coverage", "[n]o benefits are payable for injury or Sickness".

be construed in favor of Respondent's suggested construction and against that of Petitioner below.[3]

2. "Conformity With State Statutes" Language

In the "General Provisions" section of the UWL policies at issue, there exists a provision entitled "Conformity With State Statutes":

> "If a Policy provision does not conform to applicable provisions of State law, the Policy is hereby amended to comply with such law."

Petitioner's suggested construction of the Order of Benefit Determination provision and the Excess Coverage

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[3] Petitioner's suggested interpretation of the Excess Coverage language in the UWL policy violates the rule of policy interpretation in Michigan requiring that meaning be given to all terms therein. *E.g., North American Specialty Insurance Co. v. Myers,* 111 F.3d 1273 (6th Cir.1997) (interpreting Michigan law); *Advance Watch Co., Ltd. v. Kemper National Insurance Co.,* 99 F.3d 795 (6th Cir.1996) (interpreting Michigan law).

Furthermore, the language of the Excess Coverage provision of the UWL policy, when juxtaposed against the language of the Order of Benefit Determination language in the **same** policy, creates a material ambiguity as to the scope of the Order of Benefit Determination language involving the definition of "Plan". Following the universally-accepted rule of *contra proferentum,* that a material ambiguity in an insurance policy must be construed against the drafter, the Order of Benefit Determination language is to be construed so as to place primary responsibility for the payment of medical expenses on Petitioner. *Regents of the University of Michigan v. Agency Rent-A-Car,* 122 F.3d 336, 339-340 (6th Cir.1997), citing *Ford Motor Credit Co. v. Aetna Casualty and Surety Co.,* 717 F.2d 959, 961 (6th Cir.1983). *See Boyer v. Douglas Components Corp.,* 986 F.2d 999, 1005 (6th Cir.1993).

provision of the UWL policies does not conform to § 3109a of the Michigan No-Fault Act as interpreted by the Michigan Supreme Court in *Federal Kemper, supra.* Pursuant to the Conformity with State Statutes provision, the UWL policies at issue are "hereby amended to comply with such law". Thus, regardless of any other arguments proffered by Petitioner, in the end, even if the language of the UWL policies are controlling as to the relative obligations of the parties herein, that language requires that Petitioner assume primary liability for the payment of the medical expenses at issue.

II. Both the District Court and the Sixth Circuit Utilized the Procedure Outlined by this Court in *UNUM Life Insurance Co. v. Ward* in Determining that § 3109a of the Michigan No-Fault Act is Applicable to the UWL Policies at Issue in this Case by Virtue of ERISA's "Saving" Clause.

As a substantive matter, Petitioner contends that the Sixth Circuit's opinion "devotes most of its ERISA preemption analysis to whether the deemer clause overrides the savings clause when a self-funded plan is not at issue. (Apx. A, pgs. 22a-25a)". Pet. at 9-10. By focusing on those pages of the Sixth Circuit's opinion, Petitioner misapprehends the gravamen of the Sixth Circuit's analysis. In the pages immediately preceding that portion of the Sixth Circuit's opinion assailed by Petitioner, the Sixth Circuit was careful to utilize the procedure outlined by this Court in *UNUM Life Insurance Co. v. Ward, supra,* to determine whether § 3109a of the Michigan No-Fault Act was "saved" from ERISA preemption by virtue of ERISA's "saving" clause. 29 U.S.C. § 1144(b)(2)(A).

The Sixth Circuit began its analysis by observing that § 3109a fell within the purview of ERISA's preemption clause; accordingly, the next step was to determine whether it was "saved" from preemption. Pet. App A, 20a-21a. The Sixth Circuit continued:

> "This determination is made by first asking whether, from a common sense view of the matter, the provision at issue regulates insurance. *See Unum Life Ins. Co. v. Ward*, 526 U.S. 358, 367 (1999). If so, we are to consider three factors to determine whether § 3109a can be considered within the 'business of insurance' as the term is used in the McCarran Ferguson Act, 15 U.S.C. § 1011 *et seq. See id.* This three-factor inquiry involves 1) whether the practice has the effect of transferring or spreading a policy holder's risk; 2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and 3) whether the practice is limited to entities within the insurance industry. *See id.* However, the Supreme Court has qualified this three-factor inquiry, finding that a state regulation need not satisfy all three McCarran Ferguson factors in order to regulate insurance under ERISA's savings clause. *See id.* at 373."

Pet. App. A, 21a.

The Sixth Circuit then utilized that procedure in determining that § 3109a of the Michigan No-Fault Act was, indeed, "saved" from ERISA preemption. Pet. App. A, 21a-22a. The brevity of its analysis was prompted not by a misapprehension of the appropriate legal standards but by the fact that the Sixth Circuit had previously found that § 3109a was "saved" from ERISA preemption. *Northern Group Services, Inc. v. Auto Owners Insurance Co.*,

833 F.2d 85, 89-90 (6th Cir.1987). Indeed, a particularly noteworthy facet of the Sixth Circuit's analysis in *Northern Group Services* is that it followed the procedure outlined by this Court some years later in *UNUM Life Insurance Co. v. Ward, supra.*

The ensuing discussion – the portion of the opinion attacked by Petitioner – appears simply to respond to Petitioner's argument below that *Northern Group Services* has been totally overruled by subsequent case law. Pet. App A, 22a-23a. In fact, *Northern Group Services* was partly overruled, as to self-funded plans **only**, by *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990).[4] *Auto Club Insurance Association v. Health and Welfare Plans*, 961 F.2d 588, 593 (6th Cir.1992). Accordingly, the Sixth Circuit could, and did, rely on the rationale of *Northern Group Services* as applied to ERISA plans funded through insurance.

In similar measure, the Sixth Circuit's discussion of its opinion in *Lincoln Mutual Casualty Co. v. Lectron Products, Inc., Employee Health Benefit Plan*, 970 F.2d 206 (6th

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[4] Petitioner argues that § 3109a constitutes "direct" regulation of the ERISA plans at issue and, therefore, is not "saved" from ERISA preemption, because "the state priority rule does not merely regulate the conduct or policies of insurance companies, rather, the state priority rule purports to regulate the terms of all health coverage plans, irrespective of whether the plans are funded through insurance". Pet. at 18. Petitioner's formulation would obviate the need for the "deemer" clause because a state statute would not be "saved" if it reached ERISA plans not funded through insurance. Petitioner's argument appears to misapprehend the distinction that this Court made in *FMC Corp.* between direct and indirect regulation of ERISA plans. *Id.*, 498 U.S. at 61, 111 S.Ct. at 409.

Cir.1992), was in specific response to Petitioner's contention that the *Lincoln Mutual* holding should be read as including insured plans as well as self-insured plans.[5] Pet. App. A, 23a-24a. Petitioner's contention, however, ignores the fact that the argument that the ERISA plan in *Lincoln Mutual* was partly insured was based on the fact that "the employer had purchased stop-loss catastrophic claims coverage for claims above $75,000". Pet. at 25. It is well-settled that the purchase of "stop-loss" insurance does not transform a self-insured plan into an "insured plan". *American Medical Security, Inc. v. Bartlett,* 111 F.3d 358, 361 (4th Cir.1997) (citing other Fourth Circuit cases); *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga,* 801 F.2d 1157, 1161, 1162 (9th Cir.1986); *Moore v. Provident Life and Accident Insurance Co.,* 786 F.2d 922 (9th Cir.1986). *See Brown v. Granatelli,* 897 F.2d 1351, 1354 (5th Cir.1990).[6]

When the Sixth Circuit's analysis is viewed as a whole, Petitioner's substantive argument is nothing more than a claim that the Sixth Circuit "got it wrong". In fact, the weight of case law compels the opposite conclusion. But even if the Sixth Circuit had "gotten it wrong", that

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[5] The Sixth Circuit observed that various District Courts within the Circuit have interpreted *Lincoln Mutual* similarly to its reading of *Lincoln Mutual* in this case. Pet. App A., 24a-25a.

[6] District Courts even cite to *Lincoln Mutual* for that specific proposition. *E.g., Harvey v. Machigonne Benefits Administrators,* 122 F.Supp.2d 179, 185 (D. Me.2000); *G.R. Herberger's, Inc. v. Erickson,* 17 F.Supp.2d 932, 935 (D. Minn.1998); *Auto Club Insurance Association v. Safeco Life Insurance Co.,* 833 F.Supp. 637 (W.D. Mich.1993).

fact, of itself, is an insufficient basis on which to grant a petition for a writ of certiorari.

III. The Question of Whether § 3109a of the Michigan No-Fault Act is Preempted by ERISA or Saved from Preemption by ERISA's "Saving" Clause Does not Present an Issue of Sufficient Importance to Warrant Relief by this Court.

Petitioner argues that its Petition should be granted because the Sixth Circuit impermissibly broadened the scope of ERISA's "saving" clause. Pet. at 8. Indulging Petitioner's argument does not, of itself, warrant review by this Court.

With the issuance of *UNUM Life Insurance Co. v. Ward, supra,* this Court has mandated a two-step procedure for determining whether a state statute is to be "saved" from ERISA preemption. The procedure cannot be undertaken in the abstract; a court must apply the *UNUM Life* standards to a given state statute. By definition, then, the ultimate determination of whether a state statute is to be "saved" from ERISA preemption must be made on a statute-by-statute basis.

The language of state statutes, except for Uniform Acts, are rarely identical – even when dealing with the same subject-matter. Accordingly, the language of one state's statute may dictate one result. The language of another state's statute may require the opposite result. It is, therefore, more accurate to assess the impact of the Sixth Circuit's decision on federal ERISA jurisprudence in light of the number of cases wherein a Circuit or District

Court has been required to decide whether a state coordination of benefits statute was preempted by ERISA or "saved" from ERISA preemption.

Although the very nature of legal research warrants caution, it would appear that this phenomenon is, for all intents and purposes, confined to the Sixth Circuit.[7] At least two other circuits have issued opinions in cases wherein coordination of benefit provisions in ERISA plans were at issue. Neither case, however, had occasion to examine ERISA's "saving" clause in the manner undertaken by the Sixth Circuit. In *McGurl v. Trucking Employees of North Jersey Welfare Fund, Inc.*, 124 F.3d 471 (3rd Cir.1997), the Third Circuit was required to determine how to coordinate benefits between two self-funded ERISA plans with competing "other insurance" provisions. ERISA's "saving" clause was not implicated in that case because there was no state statute involved. *PM Group Life Insurance Co. v. Western Growers Assurance Trust*, 953 F.2d 543 (9th Cir.1992) involved the same scenario.

Thus, the Sixth Circuit's decision in this case is not, if history is any guide, likely to have an impact on ERISA jurisprudence in other circuits, unless the state statute involved is § 3109a of the Michigan No-Fault Act. In the absence of any more wide-ranging implications, this case does not warrant consideration by this Court.

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[7] *Winstead v. Indiana Insurance Co.*, 855 F.2d 430 (7th Cir.1988), also involved § 3109a of the Michigan No-Fault Act.

CONCLUSION

For all of the foregoing reasons, Respondent respectfully requests that this Honorable Court deny the Petition.

Respectfully submitted,

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